

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 2 8 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mary Beirne ADAMS</b>				2a. DATE OF DEATH MONTH <b>January</b> DAY <b>1</b> YEAR <b>1981</b>		2b. HOUR <b>12:35 PM</b>	
SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Mar.</b> DAY <b>1</b> YEAR <b>1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Lutherville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>College Manor</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Balto.</b>		13c. STREET ADDRESS <b>2900 St. Paul St.</b>			
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Bennett</b> LAST <b>Adams</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Caroline</b> MIDDLE <b>Blackford</b> LAST <b>Blackford</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-44-2654</b>		17. INFORMANT ADDRESS <b>Mrs. R. M. Coulbourn Balto., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> , 19 <b>66</b> , to <b>12/31</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William F. Fritz M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/2/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William F. Fritz M.D.</b>				22e. ADDRESS <b>2 W. University Pkwy., Balto., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-3-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co. Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 2 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



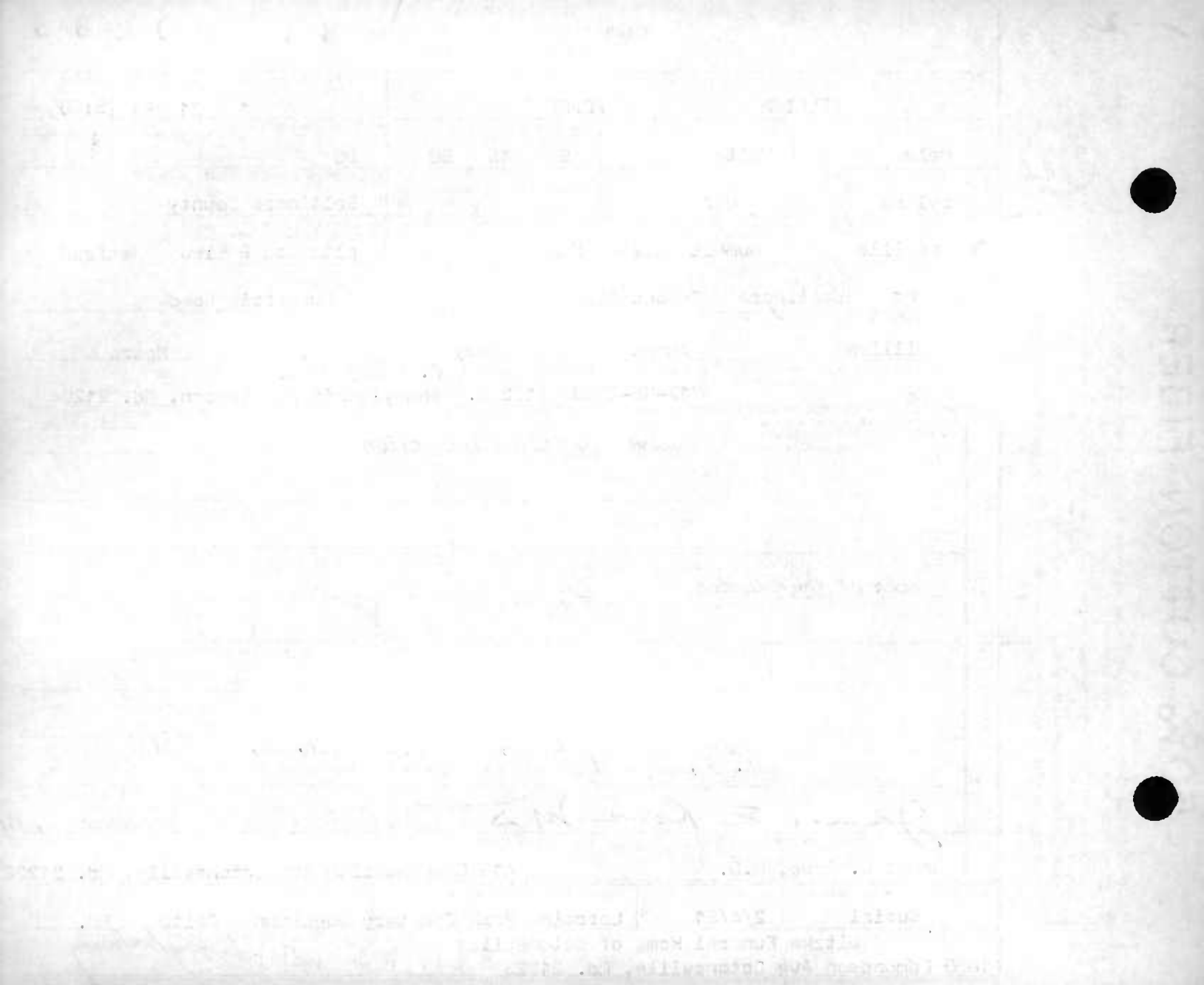
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 0 2 8 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM ADAMS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 31 81</b>		2b. HOUR <b>5:30p</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 15 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>5:30p</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Summit Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Balto Gas &amp; Elec</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13a. STATE <b>Md</b>						13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Adams</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary M. Mears</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-05-2700</b>		17. INFORMANT <b>F. Leroy Peters</b> ADDRESS <b>102 W. Pennsylvania Ave Towson, Md. 21204</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Cancer of the bladder</b> <b>COPD</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1979</b> , to <b>Jan. 31, 1981</b> , that (I) (we) last saw the deceased alive on <b>Jan. 30, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James E. Rowe M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>February 2, 1981</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James E. Rowe, M.D.</b>						22e. ADDRESS <b>413 Commonwealth Ave Catonsville, Md. 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/4/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery Woodlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Witzke Funeral Home of Catonsville</b> <b>1630 Edmondson Ave Catonsville, Md. 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>			

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## MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/5/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>	23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1981</b>	

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MELIUSE AGRAPPY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 2, 1981</b>		2b. HOUR <b>5:00 A M</b>	
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>08/15/92</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>88</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. PLACE OF BIRTH (STATE OR FOREIGN) <b>BRITISH WEST INDIES</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>BALTIMORE, COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VETERANS ADM. MED. CEN., FH, MD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unkn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Veronica</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW I</b>		16b. SOCIAL SECURITY NO. <b>212 10 6850</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITIS; BILATERAL AMPUTATION, STATUS POST</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) this hospital attended the deceased from <b>JANUARY 28, 1971</b> to <b>JANUARY 2, 1981</b> , that (X) we lost saw the deceased alive on <b>JANUARY 2, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <b>1/2/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 2 8 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH L. AHL				2a. DATE OF DEATH MONTH DAY YEAR 1/16/81		2b. HOUR 7:10 p.m.	
3 SEX Male		4 RACE Caucasian White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph H.. Ahl				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Strong			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-03-2619		17 INFORMANT ADDRESS Glen Burnie, MD L. Joseph Meldrom, 220 Wicklow Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of prostate with metastasis</u> 1850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 19 <u>81</u> , to <u>1/16</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1/16/</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. Breiteneker</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/17/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rudiger Breiteneker, M.D.				22e. ADDRESS 6701 N. Charles St., Balto, MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 19, 1981		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24 FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR JAN 20 1981		25b. REGISTRAR'S SIGNATURE <i>R. Breiteneker</i>	

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James E. Hixson, after service in the U.S. Army, was a member of the U.S. House of Representatives from 1903 to 1909.

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1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Dorothea Veronica AKERS				2a. DATE OF DEATH MONTH DAY YEAR January 14, 1981			
3 SEX Female				2b. HOUR 2:20 a.m.			
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 8 21 1915		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aide		12b. KIND OF BUSINESS OR INDUSTRY Senior Center	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13e. STREET ADDRESS 347 St. George Road	
14 FATHER'S NAME FIRST MIDDLE LAST John Heim				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret M. Younger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-01-4290		17 INFORMANT P.O. Box 337 ADDRESS Ft. Howard, MD. Lillian V. O'toole 21052			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Cardiac Arrest</u>  4310 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Subdural Hematoma</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 20</u> 19 <u>80</u> to <u>January 14</u> 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 14</u> 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <u>Neil Chamorro</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/14/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. J. Chamorro</u>				22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/1981		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.	
24 FUNERAL DIRECTOR'S NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 16 1981		25b. REGISTRAR'S SIGNATURE <u>Lillian V. O'toole</u>	
7922 Wise Avenue Dundalk, MD. 21222							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

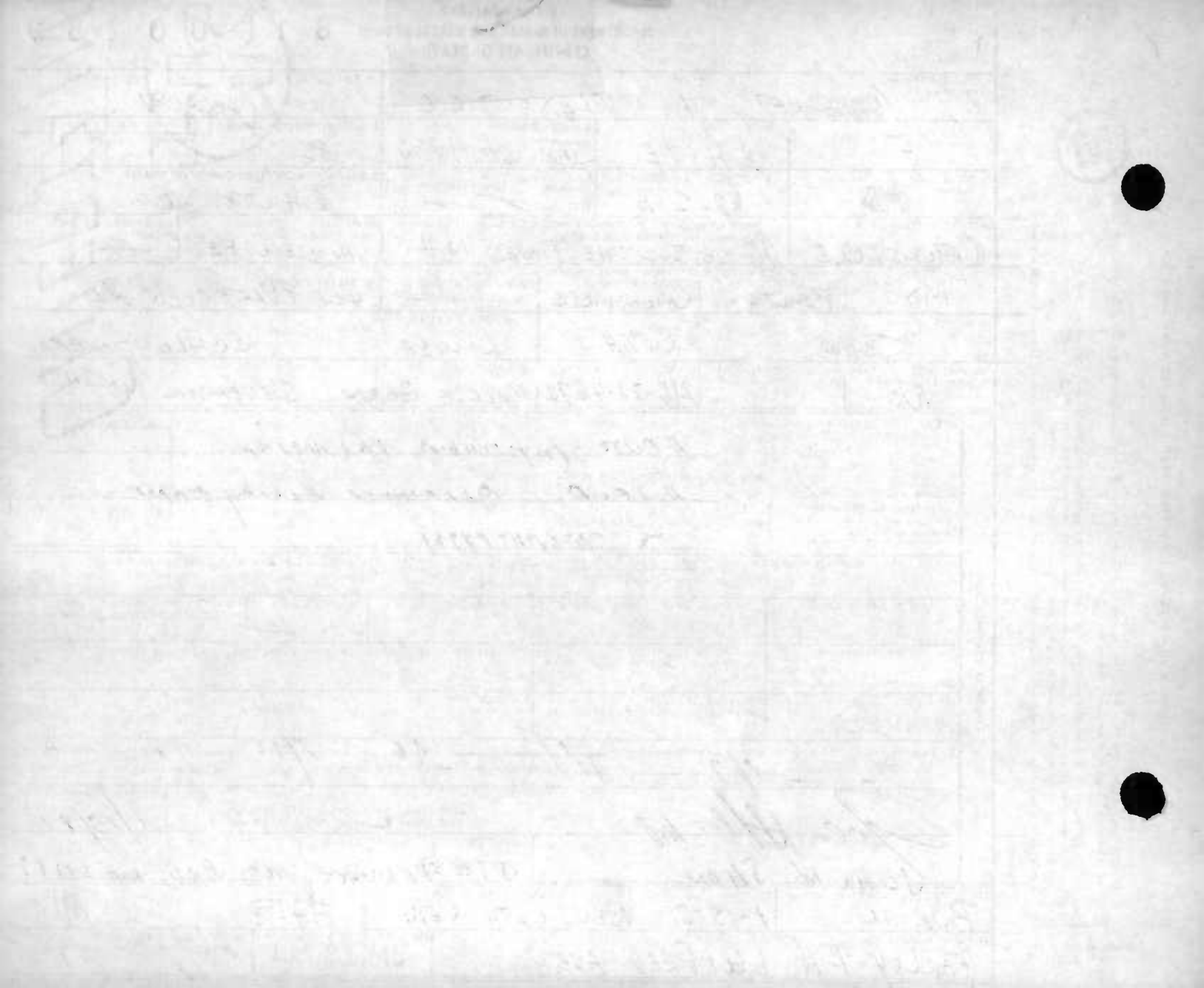
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 2 8 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>MARGARET H. ALEXANDER</u>				2a. DATE OF DEATH <u>1-12-81</u>		2b. HOUR <u>M</u>	
3. SEX <u>F</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH <u>JAN</u> DAY <u>28</u> YEAR <u>1894</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u> IF UNDER 1 YEAR: MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO. CO.</u> MD.	
10. CITY OR TOWN OF DEATH <u>CATONSVILLE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOUSE IN THE PINES N.H.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. CITY OR TOWN <u>BALTO.</u> 13c. CITY OR TOWN <u>CATONSVILLE</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>400 OVERBROOK RD.</u>	
14. FATHER'S NAME FIRST <u>JOHN</u> MIDDLE <u>—</u> LAST <u>ROTH</u>				15. MOTHER'S MAIDEN NAME FIRST <u>LOUISA</u> MIDDLE <u>—</u> LAST <u>SCHLEUPNER</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>216-28-4672</u>		17. INFORMANT NAME <u>MARGIE GORN</u> ADDRESS <u>STEVENSON MD. 21153</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE - CRONIC BILIARY TRACT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>E. MURDER</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/1/81</u> , 19 <u>80</u> , to <u>1/12/81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/7/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John H. Shaw</u> DEGREE <u>—</u>				22c. DATE SIGNED <u>1/13/81</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John H. Shaw</u>				23b. ADDRESS <u>8700 SPANGLER AVE. BALTO. MD. 21222</u>			
23c. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23d. DATE <u>1-15-81</u>		23e. NAME OF CEMETERY OR CREMATORY <u>NEW CATH. CEM.</u>		23f. LOCATION CITY OR TOWN <u>BALTO.</u> COUNTY <u>MD.</u>	
24. FUNERAL DIRECTOR NAME <u>FARLEY F.H.</u> ADDRESS <u>6601 FRED. AVE.</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 19 1981</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8555 3/24/81		7 1 0 0 2 9 0		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Oscar Lee Allen						Jan. 2-81			1:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		Negro		July 19-48		32 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.		U.S.A.				Baltimore City CO MD.			
10. PLACE OF BIRTH (CITY OR TOWN OF DEATH)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Randalstown Baltimore		Balto. Co. Gen. Hosp.				Transportation		Steel Co.	
13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS			
Md.		Baltimore				4521 Fairfax Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Zellious		Allen Sn.		Lealie		mae		Collins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		214-50-6640		Mrs. Lealie Mae Allen 4521 Fairfax Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure. Early acute myocardial infarction.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Monica Miller</u>				DEGREE PATHOLOGIST ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1, 2, 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-7-81		Anbustus Mem. Park Baltimore		Baltimore			
24. FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Randalph J. Collick				2431 E. Oliver St.		JAN 6 1981		<u>Randy Kelly</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

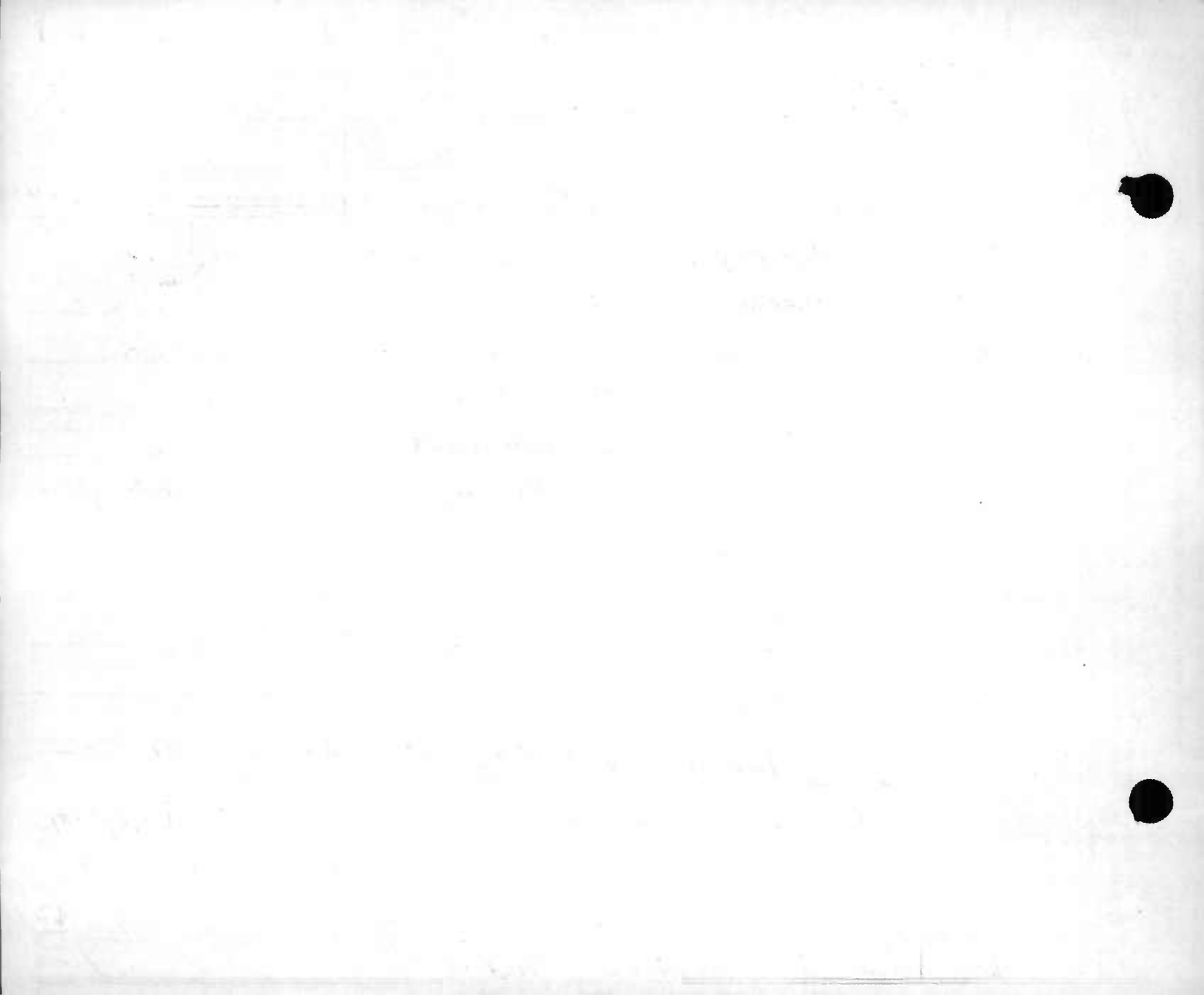
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8100291			
1. DECEASED NAME (TYPE OR PRINT) <b>Florence Virginia Anderson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>01-5-81</b>			
3. SEX <b>Female</b>				2b. HOUR <b>5:15 P.M.</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-11-1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>GARRISON, BALT CO. MD.</b>	
10. CITY OR TOWN OF DEATH <b>GARRISON, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GARRISON Valley Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hand printer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PAPER</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b> COUNTY <b>Harford</b>		13b. CITY OR TOWN <b>LAUREL</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Whisky Bottom + 170A RFE Old Camp Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joshua Howard Anderson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Sowers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-07-2209</b>		17. INFORMANT <b>Richard Anderson</b>		ADDRESS <b>170A RFD #1 Laurel, Md. 20810</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4292</b>							<b>many years</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>—</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1978</b> to <b>JAN 5 1981</b> , that (I) (we) last saw the deceased alive on <b>Dec 31 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Lawrence Boas MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>JAN 6, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LI BOAS MD</b>		22e. ADDRESS <b>5317 Belaire Rd BALT, Md 21206</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN 7, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Park Dorsey</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Donald Lee Funeral Home</b>		ADDRESS <b>Laurel Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										81	00292
1 - FOR STATE REGISTRAR										REG. NO.	
XC 13 000 073											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NORMAN ROOSEVELT ANDERSON</b>							2a. DATE OF DEATH MONTH DAY YEAR <b>1 28 81</b>		2b. HOUR <b>3:50P M</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 4 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>74</b>		IF UNDER 24 HRS. HOURS MIN. <b>3:50</b>	
7a. BIRTHPLACE (COUNTRY) <b>BRITISH WEST INDIES</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A. MEDICAL CENTER</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1119 NORTH MONROE STREET</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT ANDERSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE McKENZIE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WA OR DATES) <b>WW 11 217 26 0968</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>LARYNGEAL EDEMA</b> <b>4786</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>STATUS POST CEREBRAL CONTUSION</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/8</b> , 19 <b>80</b> , to <b>1/28</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>1/28</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE <i>Srinivasam L. Narasimhan</i>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1 1/29/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SRINIVASAM L. NARASIMHAN, M.D.</b>				22e. ADDRESS <b>V. A. MEDICAL CENTER, FORT HOWARD, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett</b>				ADDRESS <b>4600 Liberty Heights</b>				25a. DATE REC'D. BY REGISTRAR <b>AVAN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Leroy O. Dyett</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 0 0 2 9 3				
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>SIDERIS APESOS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-81</b>		2b. HOUR <b>8:10 P.M.</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 15 83</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CHIOS, GREECE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CO. TOWSON MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE TOWSON</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>LUTHERVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>MARKOS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>THEODORA POUILLADAS</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					
17. SOCIAL SECURITY NO. <b>232-03-4835</b>		18. INFORMANT ADDRESS <b>Mrs. Argetta Apesos 221 Welford Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>October 10 1980</b> to <b>1-17 1981</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b> M.D.						22c. DATE SIGNED <b>1-17-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EVANGELOS LIGNOS</b>						22e. ADDRESS <b>2016 University Pkwy, Baltimore 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-20-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CATHERINE M. BAKER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 10, 1981</b>			2b. HOUR <b>10:25<sup>AM</sup></b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 14, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CTR</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Checker-A. &amp; P. Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminister</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry C. Broughton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine E. McConnell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>					16b. SOCIAL SECURITY NO. <b>219-05-5581</b>		17. INFORMANT ADDRESS <b>Mrs. Helen Tenley 3107 Southern Ave 21214</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>5849</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE RENAL FAILURE AND DISSEMINATED INTRAVASCULAR COAGULATION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPTIC SHOCK</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b> <b>9 DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from <b>DEC. 22, 1980</b> , to <b>JAN. 10, 1981</b> , that (X) (we) lost saw the deceased alive on <b>JAN. 10, 1981</b> , and that in (my) <b>XX</b> opinion death occurred on the date and hour and from the causes stated above. (If X) (did) <b>not</b> view the body after death.										
22b. SIGNATURE <i>William J. Ottaviano</i>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/10/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J. Ottaviano</b>					22e. ADDRESS <b>Good Samaritan Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 14, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE <b>JAN 12 1981</b> <i>Barney McBrady</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>										

MEDICAL CERTIFICATION

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BALTIMORE COUNTY

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ACUTE RENAL FAILURE AND BILIRUBINEMIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		81 00295	
XC 17 107 648		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN WILLIAM BAKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 21, 1981</b>		2b. HOUR <b>11:45A M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 18, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Janitor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Butte Knit</b>
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>WESTMINSTER</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>RFD 6</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN BAKER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GERTRUDE SHIPLEY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW1</b>	
16b. SOCIAL SECURITY NO. <b>215 18 1109</b>		17. INFORMANT ADDRESS <b>Pauline Tawney 79 S. Colonial Ave. West. Md. CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FUNCTIONAL RENAL FAILURE</b> <b>5712</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CIRRHOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ALCOHOL</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>10 YEARS</b> <b>30 YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>HEPATIC ENCEPHALOPATHY, DEMENTIA</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 7, 1981</b> , to <b>JANUARY 21, 1981</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 21, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Neil D. Goldberg</i>		DEGREE		22c. DATE SIGNED <b>1/21/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NEIL D. GOLDBERG, M.D.</b>		22e. ADDRESS <b>VAMC, FORT HOWARD, MD 21052</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/23/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smallwood Carroll Md.</b>					
24. FUNERAL DIRECTOR NAME <i>Thomas D. Fletcher &amp; Son F.H.</i>		25. DATE REC'D BY REGISTRAR <b>JAN 26 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Robert McBurney</i>	



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JOHN WILLIAM HALLER JANUARY 21, 1981 11:11 AM

NAME WHITE BIRTHDATE 18, 1950

MARYLAND U.S.A. BALTIMORE COUNTY

JOHN HOWARD IV MEDICAL CENTER

MARYLAND WESTMINSTER RT. 6

JOHN BAKER CHESTER

215 18 1109 CLINICAL RECORD, VAND, JOHN HOWARD, MD

EDUCATIONAL RECORD FAILURE

10 YEARS

30 YEARS

RECORDS MANAGEMENT, MARYLAND

X

JANUARY 21, 80 JANUARY 7, 81 JANUARY 21, 81

1/21/81 X

JOHN D. COLLINGS, M.D. VAND, JOHN HOWARD, MD 11052

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 81 00297			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>DOMINICK D. BARBARA</b>				2a. DATE OF DEATH MONTH <b>01</b> DAY <b>07</b> YEAR <b>81</b> 2b. HOUR <b>4:34PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Feb</b> DAY <b>15</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC STREET</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13c. STREET ADDRESS <b>3623 Chesterfield Ave.</b>	
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE LAST <b>Barbara</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Caroline</b> MIDDLE LAST <b>Bruno</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-09-8687</b>		17. INFORMANT ADDRESS <b>Mrs. Florence E. Barbara Same as 13c</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EXTENSIVE A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Moh. Tabbaa</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. MOHAMMED TABBAA</b>				22e. ADDRESS <b>GREATER BALTIMORE MEDICAL CENTER</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 12, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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White 12 1903

U.S.A. 11 1903

1201 N. CHARLES STREET

1201 N. CHARLES STREET

Caroline 12 1903

1201 N. CHARLES STREET

ADULT HYPOCALCAEMIA

EXPERIMENTAL A.C.A. 12 1903

DIAGNOSTIC

1201 N. CHARLES STREET

1201 N. CHARLES STREET

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DOUBT AS TO NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETURN TO THE GENERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VRA15 ME(5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00296

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 23 1981										2b. HOUR M 10
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEATH MONTH DAY YEAR 1 23 1981										2d. HOUR a 7:11 M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 19 60		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7e. DATE PRONOUNCED DEATH MONTH DAY YEAR 1 23 1981		7f. HOUR a 7:11 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD						
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) York Rd. 1/5 mile n. of Shawan Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cooker		12b. KIND OF BUSINESS OR INDUSTRY McArmuck						
13a. STATE md.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 814 S. Grundy St.				
14. FATHER'S NAME FIRST MIDDLE LAST Wm. L. Bantz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Demick										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 218-58-9567		17. INFORMANT Wm. L. Bantz		ADDRESS 814 S. Grundy St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chest Compression</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? XXX 1 23 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/fixed object impact								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE York Rd. 1/5 mile n. of Shawan Rd. Baltimore Co., MD.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) Deputy Chief		MEDICAL EXAMINER				DATE SIGNED 1/23/81				
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn ST. Balto., MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-26-81		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.				
24. FUNERAL DIRECTOR NAME Thelma A. Hoffman		ADDRESS 3218 Hudson St		25a. DATE REC'D BY REGISTRAR JAN 28 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 0 2 9 8				
1- FOR STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH				
ELSIE L. BARNES										MONTH DAY YEAR				
										1 5 '81				
3. SEX					4. RACE					5. DATE OF BIRTH				
FEMALE					WHITE					MONTH DAY YEAR				
										Oct. 4, 1888				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					6. AGE (IN YEARS LAST BIRTHDAY)				
TOWSON					USA					92				
										YRS. MONTHS DAYS HOURS MIN.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					9. BALTIMORE CITY OR COUNTY OF DEATH				
TOWSON					Greater Baltimore Medical Center					BALTIMORE COUNTY MD.				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY									
Homemaker														
13a. STATE					13b. COUNTY					13c. CITY OR TOWN				
Maryland					Baltimore					Baltimore				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					13d. INSIDE CITY LIMITS?				
FIRST MIDDLE LAST					FIRST MIDDLE LAST					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Daniel Lewis					Catherine V.					3100 St. Paul Street				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
No					219-30-6405					Pickersgill Home 615 Chestnut Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Sepsis														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
Acute Tubular Necrosis														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
					P.M. 19									
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION				
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK										CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-30 19 80, to 1-5 19 81, that (I) (we) lost saw the deceased alive on 1-5 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE					DEGREE					22c. DATE SIGNED				
K. DYAL-DOTTIN					M.D.					1/5/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
K. DYAL-DOTTIN, M.D.					GBMC-6701 N. CHARLES									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
Burial					1/9/81					Oaklawn Cemetery				
23d. LOCATION					23e. DATE REC'D. BY REGISTRAR					23f. REGISTRAR'S SIGNATURE				
CITY OR TOWN COUNTY STATE					JAN 7 1981					Baltimore Maryland				
24. FUNERAL DIRECTOR														
Ruck Towson Funeral Home, Inc. 1050 York Road														

2101

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8100299	
1. DECEASED NAME (TYPE OR PRINT) <b>BENJAMIN NUN BARR</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1-07-81</b>				2b. HOUR <b>12<sup>30</sup> P.M.</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>NOV. 4, 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7d. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10 CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>RANDALLSTOWN</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. 101 3911 NOYES CIR. #21133</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM LOUIS BARR</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DORA WHITMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>216-01-1946</b>		17 INFORMANT <b>MRS. ARLENE BLUM</b> ADDRESS <b>4 FARMHOUSE COURT BALTO., MD 21208</b>							
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>same day</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a) <b>Hypertension</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1964</b> to <b>present</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>11-7-</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sheldon C. Kravitz, M.D.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-8-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHELDON KRAVITZ, M.D.</b>				22e. ADDRESS <b>7620 YORK RD. 201 E. University Pkwy</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 9, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HAR SINAI BENEVOLENT SOC.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>					
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; SONS, INC.</b>				24b. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Walter McCreedy</b>			



5

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Agnes		L.		Barrett		1		22		19		81					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
female		white		Oct. 19, 1904		76		MONTHS		DAYS		HOURS		MIN		1		23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.										Baltimore		County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Towson		Tabco Towers 305 E. Joppa Road		Meat Wrapper		Food Fair													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		305 E. Joppa Road											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Charles		Edward		Seliman		Agnes		Mae		Stallings									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		217-16-8554		Mr. Joseph L. Barrett		1 Collis Court													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED		1/24/81													
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, M.D.		ADDRESS		111 Penn Street, Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		DATE									
Burial		1-27-1981		Oak Lawn		Baltimore		Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Ruck Towson Funeral Home, Inc.		1050 York Road Towson, Maryland		JAN 27 1981		P. J. H. H. H.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 3 0 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JOAN MARIE BARRETT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 22, 1981</b>		2b. HOUR <b>6:45p</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 16, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Essex</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1709 Ann Ave. 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Bach</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Baker</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216 24 8941</b>		17. INFORMANT (Brother) ADDRESS <b>Francis J. Bach, Sr. 5 Bladen Road 21221</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4850 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchopneumonia with Brain Abscesses &amp; Meningitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <b>January 12, 1981</b> , to <b>January 22, 1981</b> , that (X) (we) lost saw the deceased alive on <b>January 22, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Carolyn J. Rose, MD</b> DEGREE				22c. DATE SIGNED <b>1/22/81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carolyn J. Rose</b>	
22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>				22f. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-26-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home PA 1407 Old Eastern Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b> 25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>			



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NAME	ADDRESS	CITY	STATE	ZIP
JOHN DOE	123 MAIN ST	ANYTOWN	CA	90210
JANE DOE	456 MAIN ST	ANYTOWN	CA	90210
JOHN DOE	789 MAIN ST	ANYTOWN	CA	90210

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Follow-up must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 0 3 0 2	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eula B. Bartlebaugh			2a. DATE OF DEATH MONTH DAY YEAR Jan. 25, 1981		2b. HOUR 9:25 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, Co., MD		
10. CITY OR TOWN OF DEATH 21234	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7220 Sindall Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY Local Govt.
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN 21234	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Moore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Gibbs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. ----- 299-07-4481	17. INFORMANT ADDRESS 21234 John W. Powell 7220 Sindall Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mmw
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>80</u> , to <u>Jan</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Dec 29</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Sheldon Goldgeier</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/26/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheldon Goldgeier, M.D.		22e. ADDRESS 711 W. 40th. Street 366-1838			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 28, '81	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR JAN 26 1981		25b. REGISTRAR'S SIGNATURE <u>Richard H. Brady</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Richard Charles Bauer Sr.</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>10</b> YEAR <b>81</b>			2b. HOUR <b>6<sup>05</sup></b> AM			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>8</b> YEAR <b>97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate Sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>MD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3722 Dance Mill Rd</b>	
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Paul</b> LAST <b>Bauer</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Caroline</b> LAST <b>Gerber</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-01-798</b>		17. INFORMANT NAME <b>Richard C. Bauer, Jr.</b> same as #13e ADDRESS <b>Stella Maris Hospice</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute M.I.</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.V.D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b>C.H.F</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-22</b> , 19 <b>75</b> , to <b>1-10</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1-9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Eddie NAKHODA M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-10-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eddie NAKHODA M.D.</b>						22e. ADDRESS <b>STELLA MARIS Hospice</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-13-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>Maryland</b> STATE		
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>1050 York Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION



UNITED STATES  
NATIONAL ARCHIVES  
COLLIER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 1 0 0 3 0 4					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Minnie		G.		Beall	January	16,	1981		7:00 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	Caucasian	May 3, 1888		92		YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Catonsville	Shangri-La Nursing Center		Housewife		Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
Unknown		"Goertze"		No N/A					
16a. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
213-74-9922		Mr. Maurice Beall		Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		Congestive Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4292		Congestive Heart Failure		2 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Arterio-sclerotic Cardio-Vascular		15 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes Mellitus; Lymphatic LEUKEMIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 53, to Jan 16, 19 81, that (we) last saw the deceased alive on Jan 15, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
J. Nelson McKay, M.D.		MD				1-17-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR					
J. Nelson McKay, M.D.		1132 N. Rolling Rd. Balt., Md. 21228		22g. REGISTRAR'S SIGNATURE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		1/19/81		New Cathedral		Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MacNabb Funeral Home		Catonsville, Md.		JAN 22 1981		History, McBrady			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 3 0 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARTHA E BEETHAM</b>				2a. DATE OF DEATH MONTH <b>01</b> DAY <b>25</b> YEAR <b>81</b>		2b. HOUR <b>10:40P</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>7</b> YEAR <b>1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Rodgers Forge</b>	
14. FATHER'S NAME FIRST <b>T.</b> MIDDLE <b>Allen</b> LAST <b>Beetham</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Covert</b> LAST <b>Covert</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220 44 2677</b>		17. INFORMANT ADDRESS <b>Suzanne Wagner 1903 Rushley Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> , 19 <b>81</b> , to <b>1/25</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1/25</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles C. Brown</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/26/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles C. Brown, M.D.</b>				22e. ADDRESS <b>6701 North Charles Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/28/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Md</b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home 6500 York Rd.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Butler</b>	



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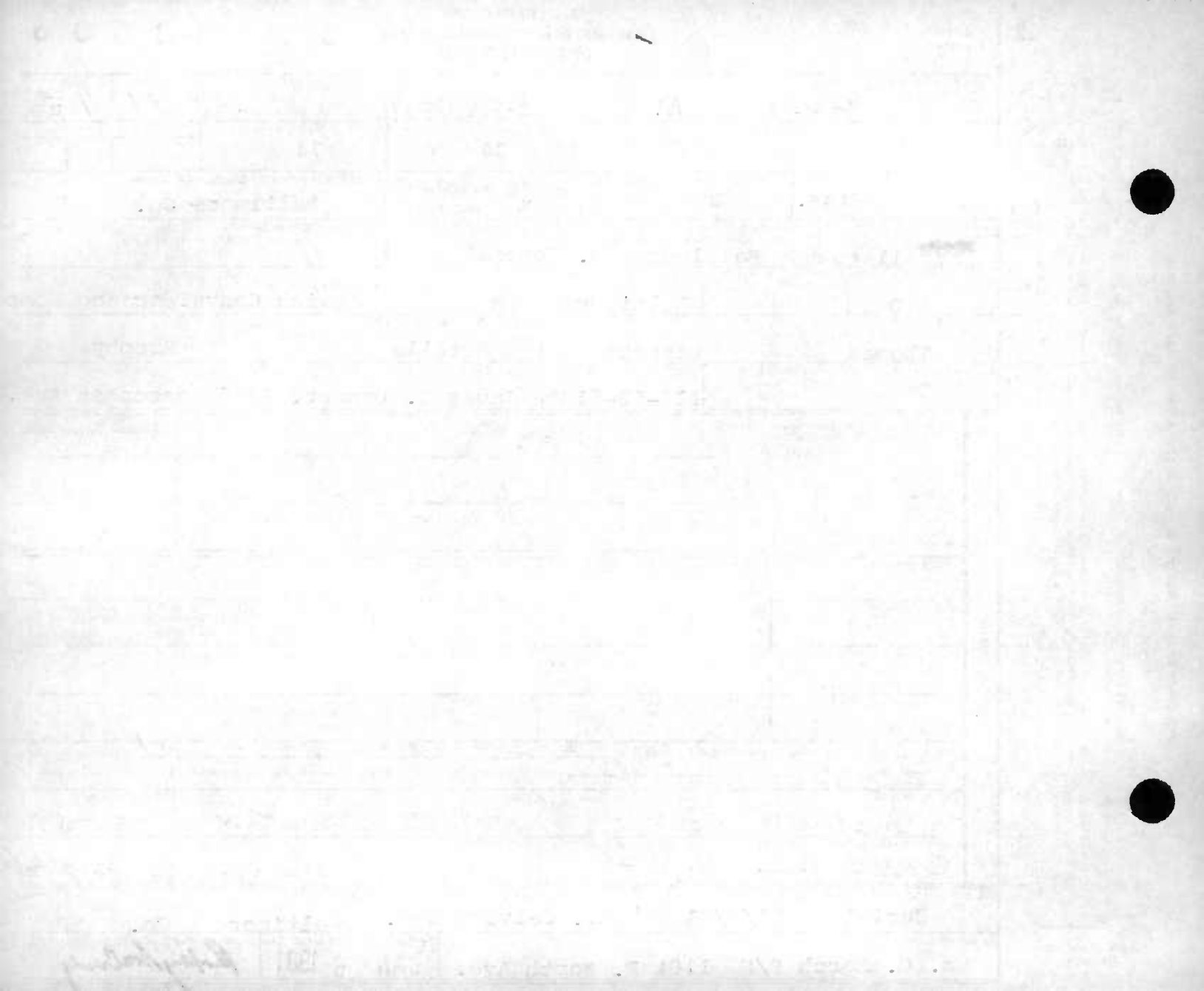
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with an original death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8100306			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HENRY M BENNETT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-5-81</b> 7b. HOUR <b>11:30 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>10<sup>TH</sup> 20 06<sup>R</sup></b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Miss.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>Jewish Convalescence Home</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Bennett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estella Murphy</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>134-05-5199</b>		17. INFORMANT ADDRESS <b>James E. Bennett 4025 Rosecrest Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>heart failure</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>years</b>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-29-</b> 19 <b>80</b> , to <b>1-5-</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1-5-</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Soonchul Hong</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-5-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOONCHUL HONG</b>				22e. ADDRESS <b>Baltimore County General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/8/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1981</b> 25b. REGISTRAR'S SIGNATURE <b>Robert K. Calverly</b>	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 0 7

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: <u>Thelma</u> Middle: <u>E</u> Last: <u>Benson</u>			2a. DATE OF DEATH MONTH: <u>January</u> DAY: <u>3</u> YEAR: <u>1981</u>		2b. HOUR <u>M</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH: <u>Oct.</u> DAY: <u>21</u> YEAR: <u>1916</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>64</u> YRS.	IF UNDER 1 YEAR MONTHS: _____ DAYS: _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD	
10. CITY OR TOWN OF DEATH <u>Towson</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St Joseph Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>President Camping Trailers Co</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: <u>Maryland</u> 13b. COUNTY: <u>Anne Arundel</u> 13c. CITY OR TOWN: <u>Annapolis</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First: <u>Charles</u> Middle: <u>W</u> Last: <u>Ironmonger</u>			15. MOTHER'S MAIDEN NAME First: <u>Lula</u> Middle: <u>A</u> Last: <u>Muller</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>217-20-7776</u>		17. INFORMANT ADDRESS: <u>Glen Arm, Md</u> <u>Mrs Patricia E Rybak 11648 Manor Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERWAY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR: _____ A.M. MONTH: _____ DAY: _____ YEAR: <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>—</u>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>		21f. LOCATION STREET: <u>176</u> CITY OR TOWN: <u>Dec 29</u> COUNTY: <u>SO</u> STATE: <u>—</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>1976</u> to <u>Dec 29</u> 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>Dec 29</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Daniel C Wilkerson</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>1/5/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Daniel C Wilkerson M.D.</u>		22e. ADDRESS <u>1563 St Margarets Rd Annapolis Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>1/7/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
23d. LOCATION CITY OR TOWN: <u>Baltimore, Maryland</u> COUNTY: _____ STATE: _____					
24. FUNERAL DIRECTOR NAME: <u>Leonard J Ruck Inc. Baltimore, Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 5 1981</u>		25b. REGISTRAR'S SIGNATURE <u>Jeffrey Halbrudy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 0 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rose Berman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1-16-81</i>			2b. HOUR <i>4:40</i> M	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>OCT. 14, 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>78</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO County</i> MD.	
10. CITY OR TOWN OF DEATH <i>RANDALLSTOWN</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BCCM</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. STREET ADDRESS <i>3306 SOUTHGREEN RD. #21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>SIMON HURWITZ</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>FANNIE ALEXANDER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-74-4358</i>		17. INFORMANT <i>MR. THEODORE HAD Berman</i> <i>3306 SOUTHGREEN RD. #21207</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*4100*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*1 hr.**20 years*

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

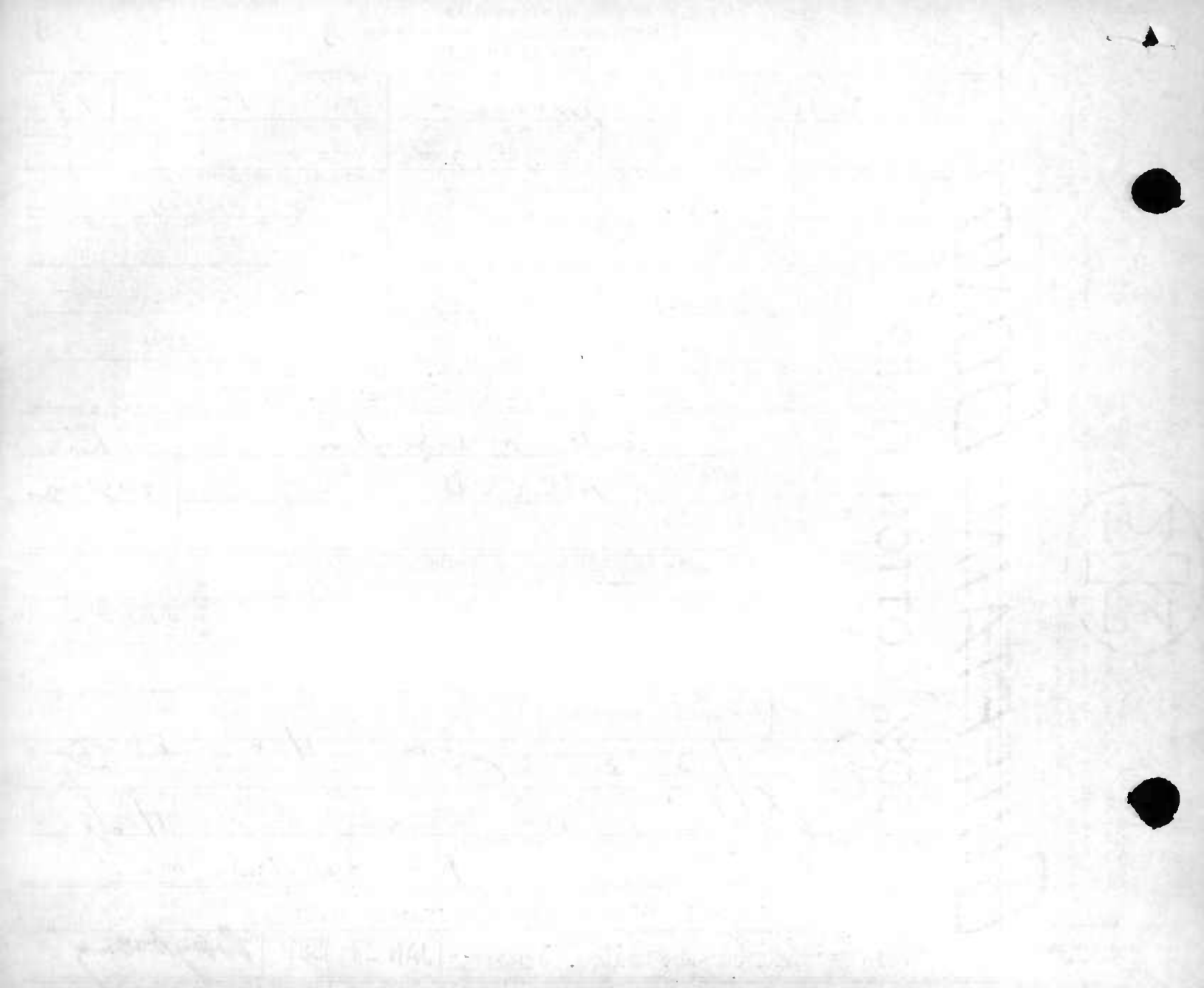
19a. DATE OF OPERATION <i>1/16/81</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>—</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/16/81</i> to <i>1/16/81</i> , that (I) (we) last saw the deceased alive on <i>1/16/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M. T. Ellin</i>		DEGREE <i>MD.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>1/16/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. T. Ellin</i>		22e. ADDRESS <i>Randallstown, Md.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>1-18-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MIKRO KODESH-BETH ISRAEL</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MD</i>	
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD., BALTO., MD 21215</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				81 00309			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST FREDERICK Bloom				2a. DATE OF DEATH MONTH DAY YEAR Jan. 12 1981		2b. HOUR 3:45 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY VIEW NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Penn. Railroad	
13a. STATE MD.				13b. CITY OR TOWN BALTO.		13c. STREET ADDRESS 9225-0 THORNTON ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES Bloom				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET LENTZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 000-07-6233		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral sclerosis DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic CV disease 3419 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Mega colon, distention							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/17, 1974, to 1/12, 1981, that (I) (we) lost saw the deceased alive on 1/12, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE H. Koetter				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/13/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HANS J. KOETTER, M.D.				22e. ADDRESS 7600 OSLER DRIVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-15-1981		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL				25a. DATE REC'D. BY REGISTRAR JAN 14 1981		25b. REGISTRAR'S SIGNATURE L. J. [Signature]	
ADDRESS 8800 HARTFORD RD.							

BP



REPORT NOTED 6% OF

AMERICAN MATHEMATICS

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "NOTED" are visible.]*

*[Handwritten signature or initials at the bottom left.]*

1981 2 17 4:10 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

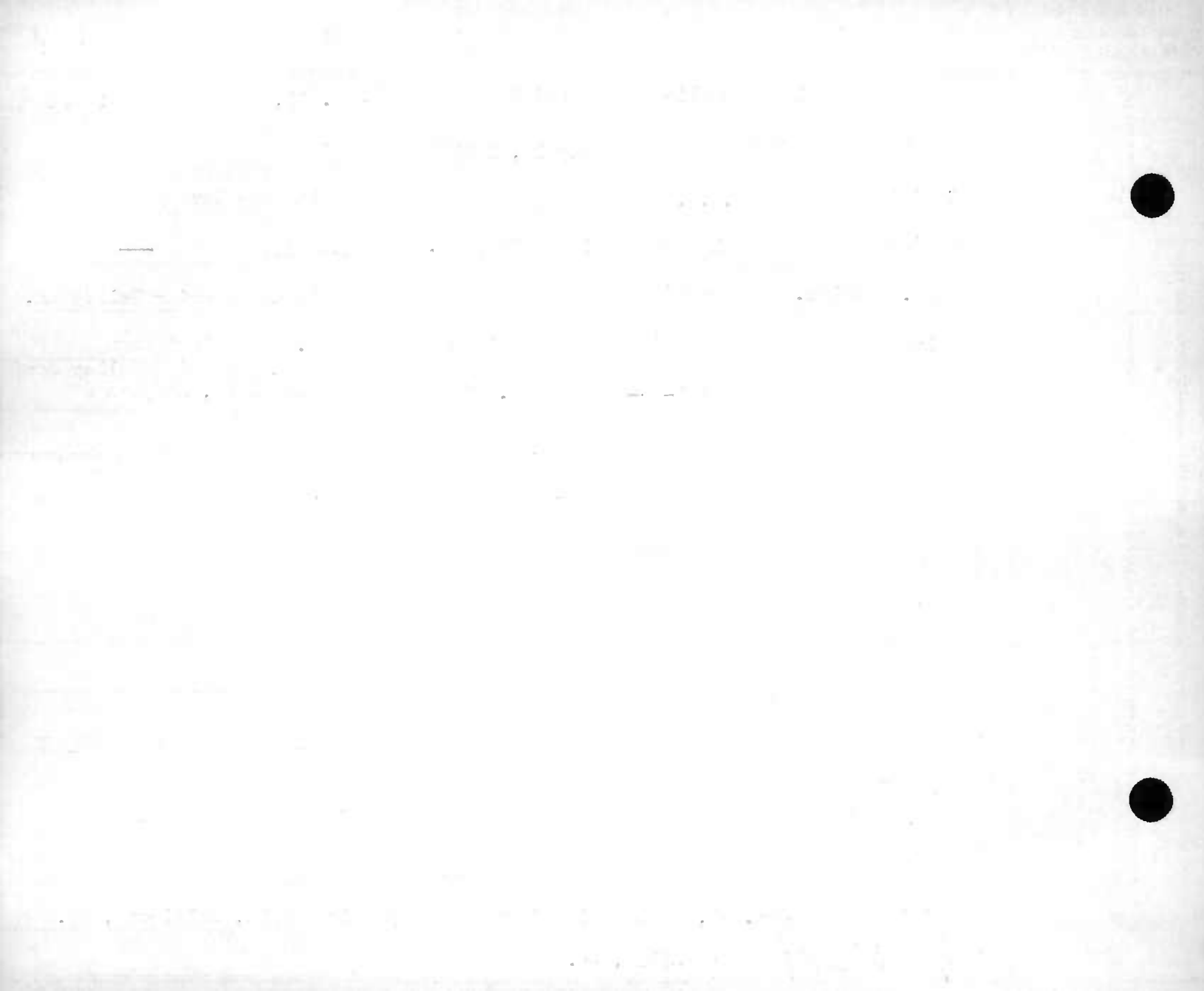
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8100310			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pearl Aurelia Bodensick				2a. DATE OF DEATH MONTH DAY YEAR Jan. 21, 1981			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 19, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10 CITY OR TOWN OF DEATH Garrison		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19 Greenspring Valley Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto. Garrison				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 19 Greenspring Valley Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Clark Lewis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth M. Patterson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-14-9051		17 INFORMANT ADDRESS Mrs. Richard Baker Garrison, Maryland 19 Greenspring Valley Road			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic CV Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Years</u> <u>Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-10</u> , 19 <u>72</u> , to <u>1-21</u> , 19 <u>81</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>1-20</u> , 19 <u>81</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death.							
22b. SIGNATURE <u>C.E. McWilliams</u> M.D.				22c. DATE SIGNED 1-21-81		22d. PHYSICIAN'S NAME (TYPE OF PRINT) C.E. McWilliams	
22e. ADDRESS 11904 Kesterton Rd. Kesterton Md 21136				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 23, 1981		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Baltimore Md.	
24 FUNERAL DIRECTOR NAME <u>H. Ehlhardt</u>				24b. ADDRESS Owings Mills, Md.		25a. DATE RECEIVED BY REGISTRAR JAN 23 1981	
25b. REGISTRAR'S SIGNATURE							

BP \_\_\_\_\_



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8100311			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAUDE SMITH BOEHM				2b. HOUR A 4:10 M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 1, 1890		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY State of Md.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST James Buchanan Smith				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Jane Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03-4511		17 INFORMANT ADDRESS 321 Stevenson Lane G. Richard Thompson Towson, Md. 21204			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/14/81</u> 19 <u>81</u> to <u>1/17/81</u> 19 <u>81</u> that (I) (we) last saw the deceased alive on <u>1/14/81</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (have) (did not) view the body after death.							
22b. SIGNATURE <u>T.C. Siwinski</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>1/19/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thaddeus C. Siwinski, M.D.				22e. ADDRESS 206 W. Pennsylvania Ave. Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 20, 1981		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Baltimore, Md.				25a. DATE OF F.D. BY REGISTRAR JAN 22 1981		25b. REGISTRAR'S SIGNATURE	



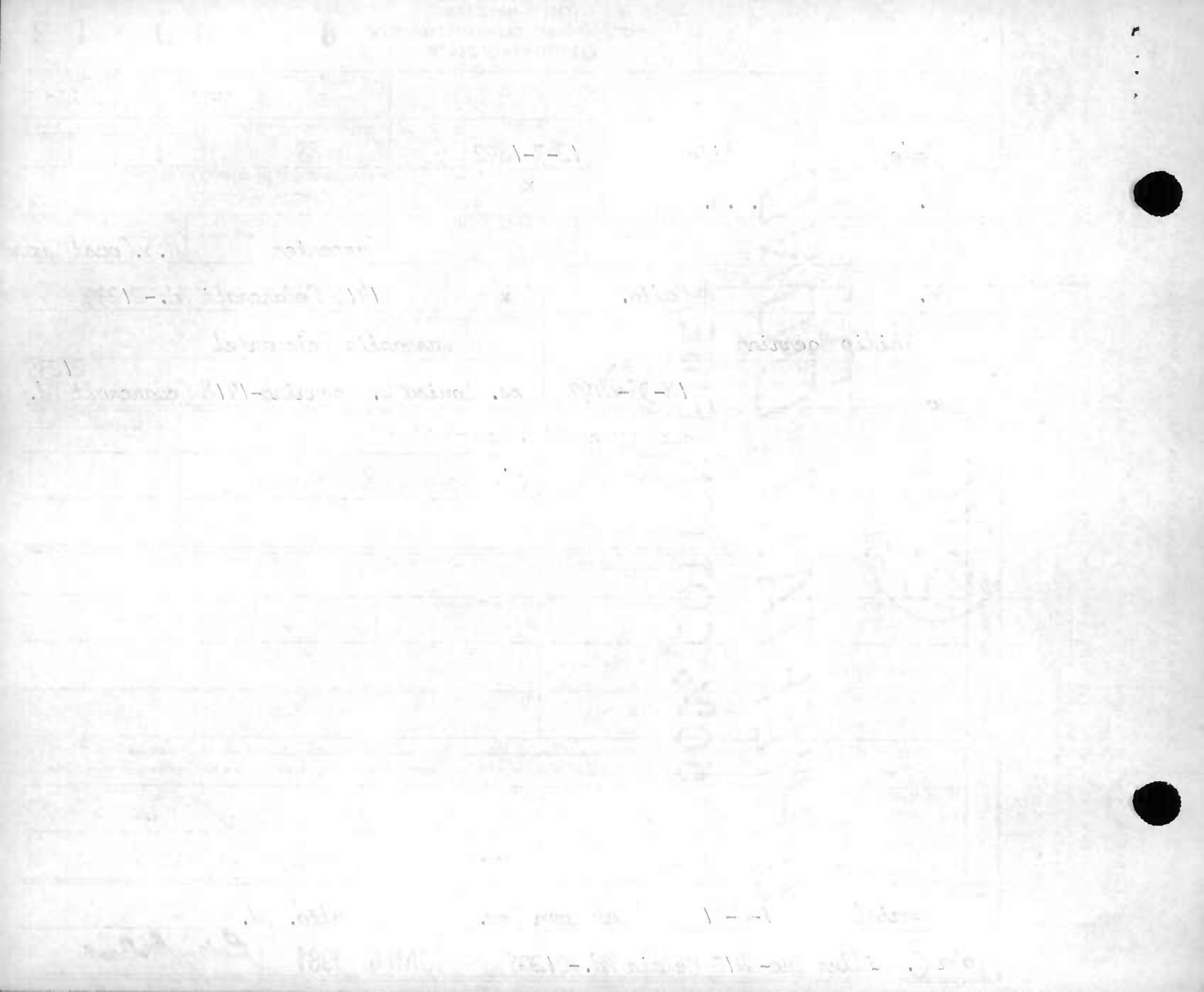
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 3 1 2 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR Jan. 2, 1981				2b. HOUR 2:14p M	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD E. BOENNING				3. SEX Male				4. RACE White	
5. DATE OF BIRTH MONTH DAY YEAR 12-7-1892				6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter				12b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard					
13a. STATE Md.				13b. COUNTY Baltimore				13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST Philip Boenning				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margarita Weismantel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-36-8499				17. INFORMANT ADDRESS Mrs. Louisa G. Boenning-1418 Cedarcroft Rd. 21239	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Serratia marcescens pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 10, 1980, to Jan. 2, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Jan. 2, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Beatriz P. Dizon, M.D.				DEGREE M.D.				22c. DATE SIGNED Jan. 2, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beatriz P. Dizon, M.D.				22e. ADDRESS 7620 York Road Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-6-81		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206				25a. DATE REC'D. BY REGISTRAR JAN 6 1981				25b. REGISTRAR'S SIGNATURE R. H. McBrady	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMM - 17  
(VR A15 ME (5))  
15M 2/80

Items #10a-22a Film G553 3/10/81 DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00313	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		KNOWN <input type="checkbox"/> MONTH DAY YEAR ESTIMATED <input checked="" type="checkbox"/> 1 19 81		2b. HOUR	
Lorita		Alice		Booze									
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR		
female	black	MONTH DAY YEAR		LAST BIRTHDAY	MONTHS DAYS		HOURS MIN.		1 20 19 81		2:00 PM		
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Baltimore County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		3442 Carriage Hill Circle											
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Maryland		BALTO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3442 Carriage Hill Circle							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Herbert		L. Booze		Marian		Kinney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
		213-30-2278		Marian Booze		1236 N. Curley Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:													
4254 IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
								STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
<u>Hormez R. Guard</u>				M.D. Assistant				1/21/81					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Hormez R. Guard, M.D.				111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				1/24/81		Mount Calvary Cemetery				Baltimore COUNTY STATE MD.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
WILLIAM C. MARCH F/H Inc.						1101 E. North Ave.		JAN 22 1981				<u>Hormez R. Guard</u>	

RECEIVED

1964 JUN 10

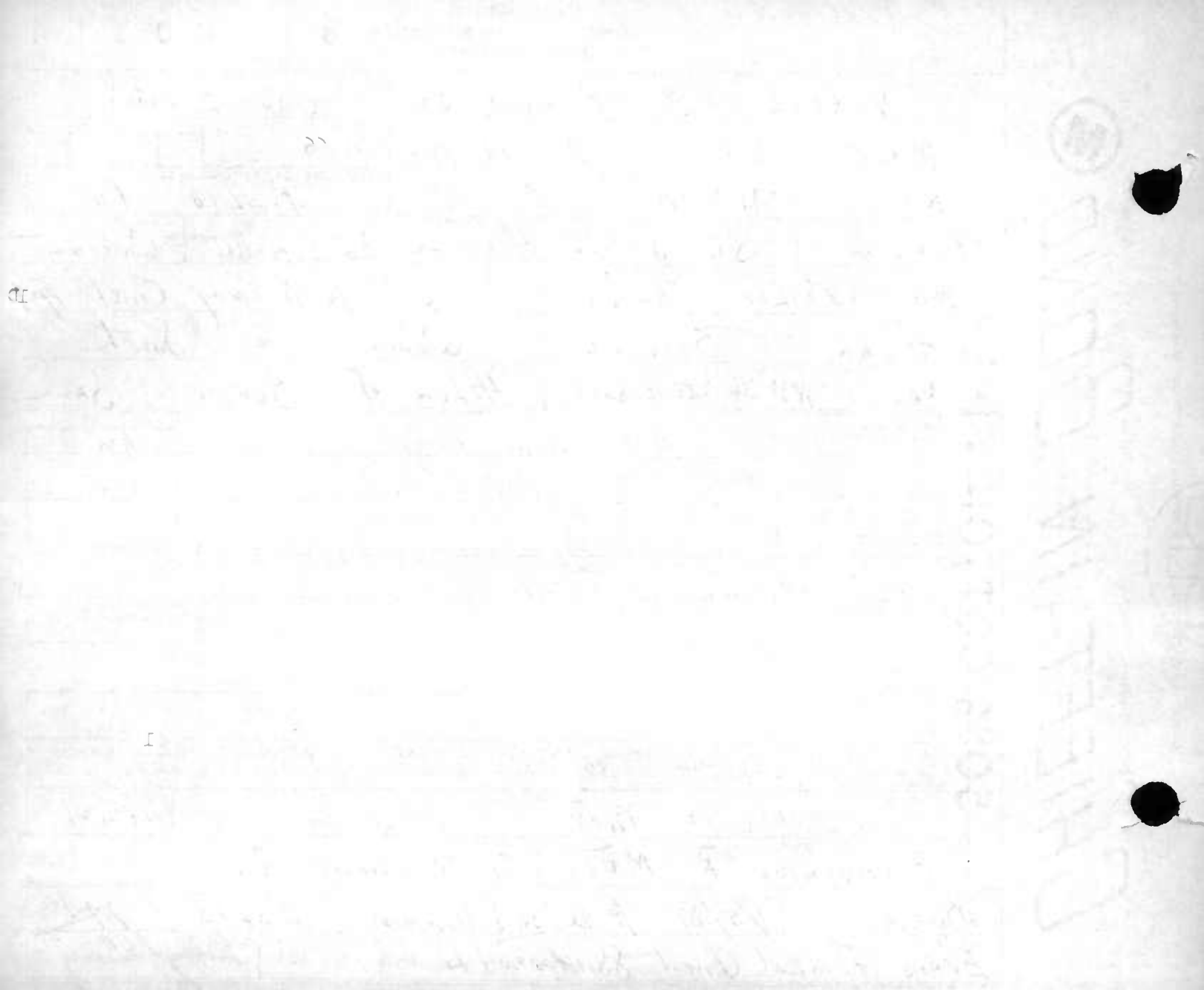
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8100314			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virgil S Bowser Jr				2a. DATE OF DEATH MONTH DAY YEAR Jan 2 1981			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 29 1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ky.		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CO MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ed. Specialist		12b. KIND OF BUSINESS OR INDUSTRY Gov. emt	
13a. STATE Md				13b. COUNTY BALTO		13c. CITY OR TOWN Towson	
14. FATHER'S NAME FIRST MIDDLE LAST John Bowser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Grace Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 400-16-8393		17. INFORMANT ADDRESS Helen J. Bowser Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5334 G.I. hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Peptic ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA & left hemiplegia (old)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hr. years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 80, to Jan. 2 19 81, that (I) (we) lost saw the deceased alive on Dec. 30 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. Mator, M.D.				DEGREE		22c. DATE SIGNED 11/5/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bienvenido R. Mator				22e. ADDRESS 21 Cranbrook Rd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/5/81		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME Evans Funeral Chapel				25a. DATE REC'D. BY REGISTRAR JAN 6 1981		25b. REGISTRAR'S SIGNATURE	



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

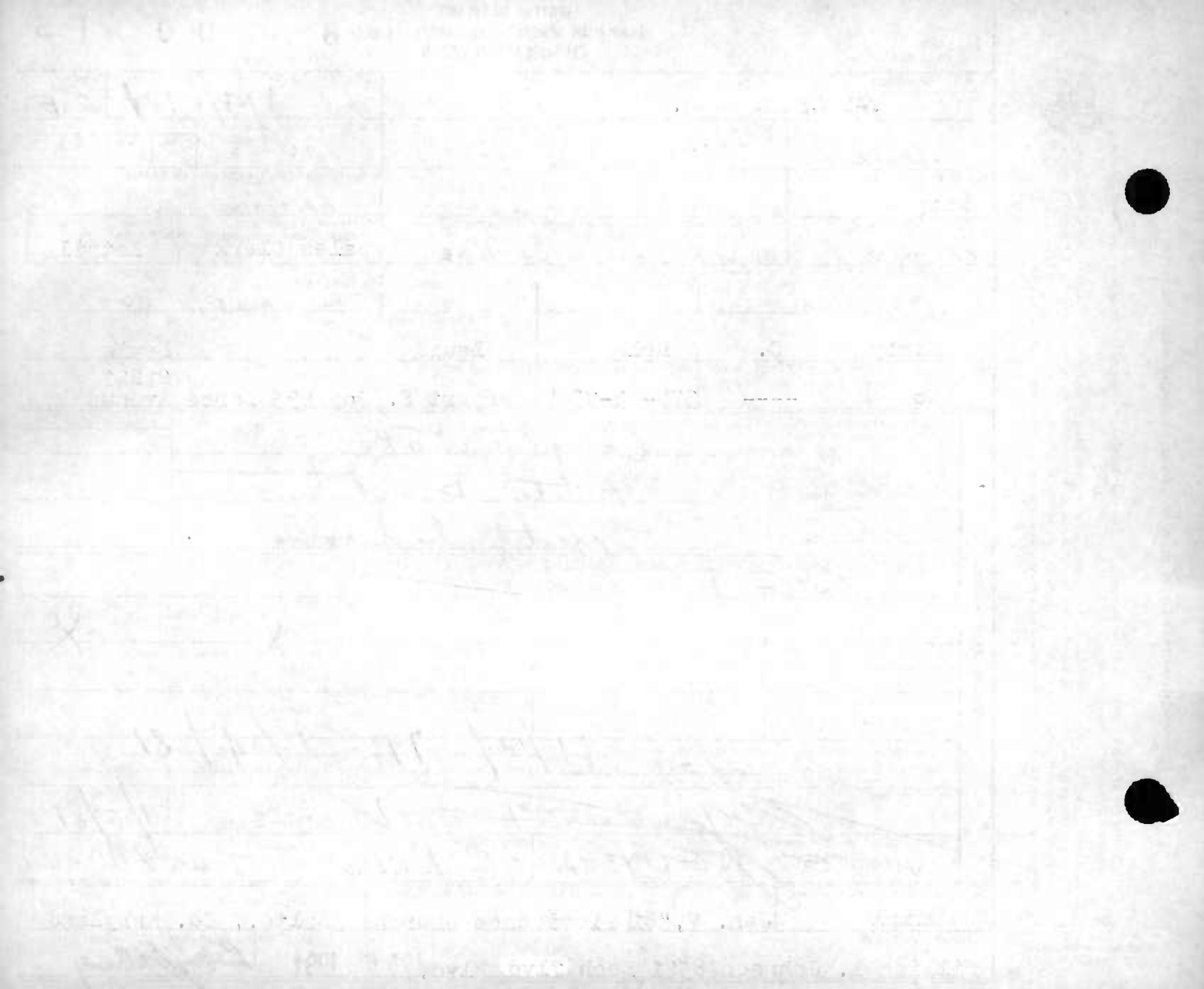
8 1 00315

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHERINE M. BOYD			2a. DATE OF DEATH MONTH DAY YEAR 1/4/1981		2b. HOUR 2:00 P.M.
3. SEX female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 3 99		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD.		
10. CITY OR TOWN OF DEATH BALTO CO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY VIEW NSG HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk	12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE MD			13b. COUNTY BALTO.	13c. CITY OR TOWN 21234	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Harry C. Held			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Lewis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----	17. INFORMANT ADDRESS Herbert S. Guy 935 Lance Avenue 21221		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete stroke DUE TO, OR AS A CONSEQUENCE OF (b) Acute Bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) Infected bed sores 4660 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) N-G tube feeding					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/12/79 to 1/4/81, that (I) (we) last saw the deceased alive on 12/29/80, and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE NGUYEN		22c. PHYSICIAN'S NAME (TYPE OR PRINT) NGUYEN		22d. ADDRESS 6 Linlow Ct Towson MD 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 7, '81		23c. NAME OF CEMETERY OR CREMATORY Providence Church	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Co. Maryland		25a. DATE REC'D. BY REGISTRAR JAN 6 1981			
24. FUNERAL DIRECTOR NAME William E. Johnson		25b. REGISTRAR'S SIGNATURE Ruthy M. Brady			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-356-3300.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO. 8 1 0 0 3 1 6										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EUGENE R. BRENNAMAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 14 '81</b>					2b. HOUR <b>6:15A</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 21 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGINEER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HEAT. *COOL.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>					13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SCOTT BRENNAMAN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOLA BEANE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-05-1887A</b>		17. INFORMANT <b>MARY RUTH BRENNAMAN</b>			ADDRESS <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>POSSIBLE PULMONARY EMBOLISM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b>MULTIPLE CEREBROVASCULAR ACCIDENT, SEVERE PERIPHERAL VASCULAR DISEASE</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>ADULT ONSET DIABETES MELITUS</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/14 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>11/14 1981</b> to <b>1/14 1981</b> , that (I) (we) lost saw the deceased alive on <b>1/14 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Approuve N-U-Vanguri</b>				DEGREE <b>M-D,</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1/14/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. VANGURI, M.D.</b>				22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-17-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODLAWN BALTO MD</b>		23e. DATE REC'D. BY REGISTRAR <b>JAN 16 1981</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>HENRY W. JENKINS &amp; SONS CO., BALTO., MD.</b>										

1 10 101 1151

BRENNAN

EUGENE

BALTIMORE COUNTY

WHITE

WILE

1010-6501 M. CHARLES ST.

TOWSON

ADJUTANT GENERAL'S OFFICE

POSSIBLE BULLETHOLE

MULTIPLE BULLETHOLE

ADULT ONSET OF DIABETES

1010-6501

TO

1010-6501

BY

1010-6501

1010-6501

1010-6501 M. CHARLES ST.

1010-6501 M. CHARLES ST.

1010-6501

1010-6501

1010-6501

1010-6501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 1 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLOTTE H. BROOKS</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>22</b> YEAR <b>'81</b>	
3. SEX <b>FEMALE</b>		2b. HOUR <b>2:45A</b>	
4. RACE <b>WHITE</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.	
5. DATE OF BIRTH MONTH <b>8</b> DAY <b>9</b> YEAR <b>30</b>		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>	
13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Curran</b> MIDDLE <b>W.</b> LAST <b>Harvey</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Charlotte</b> MIDDLE <b>C.</b> LAST <b>Cromwell</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-30-0119</b>	
17. INFORMANT <b></b>		ADDRESS <b>1212 West Joppa Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOXIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>BILATERAL PLEURAL EFFUSION LUNG CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>GENERALIZED CARCINOMATOSIS</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-20</b> , 19 <b>81</b> , to <b>1-22</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1-22</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Kamal Dyal-Dottin</b>		DEGREE <b>MBS</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED <b>1/22/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. DYAL-DOTTIN</b>		22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/22/81</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1981</b>	
		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	

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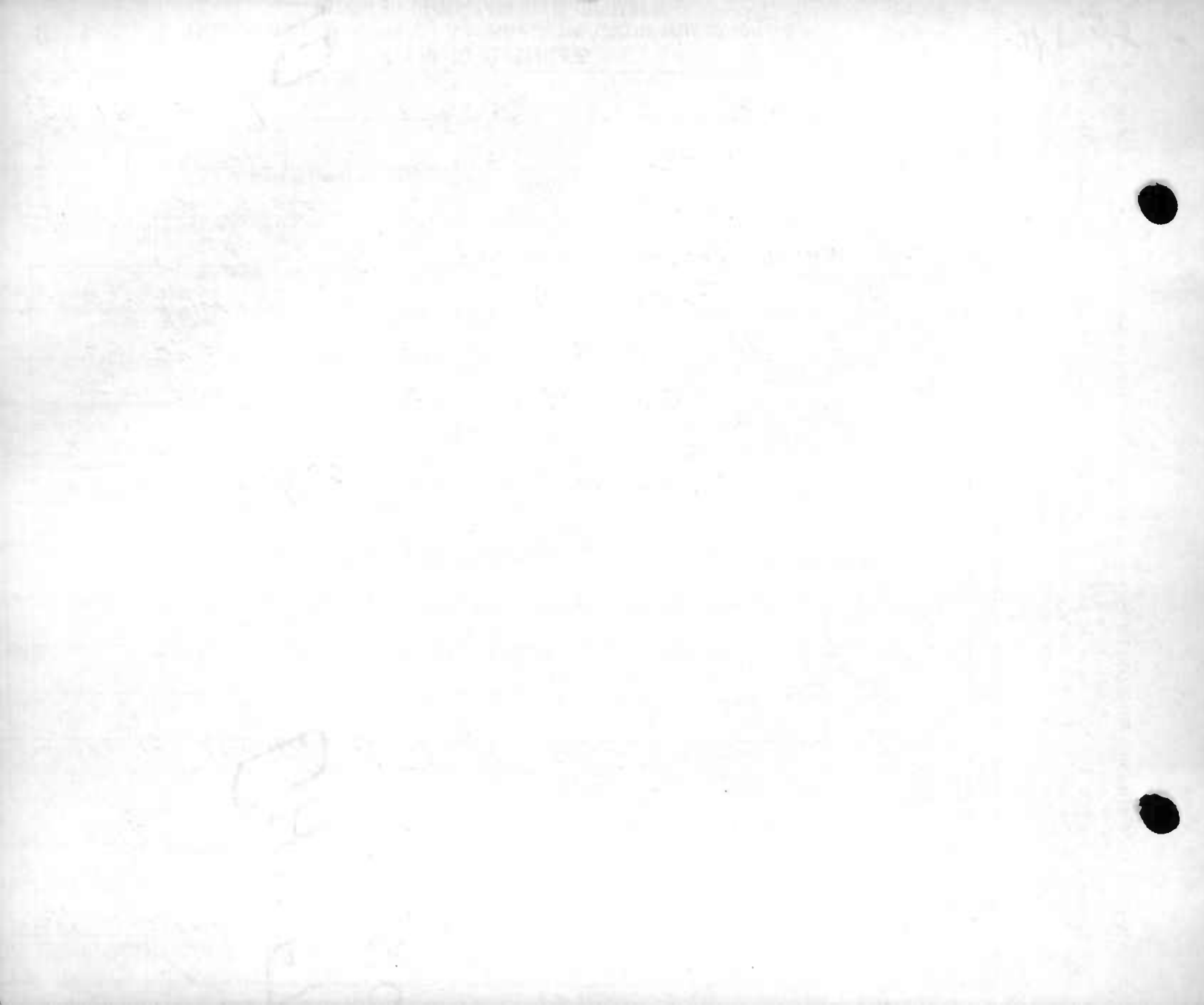
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0 3 1 8  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Beulah E. Brown</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>81</b>			2b. HOUR <b>12:44</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>FEB. 20, 1888</b>		6. AGE (In years last birthday) <b>92</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO. CO.</b>	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RANDALLSTOWN N.H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>PIKESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>W.</b> Last <b>CHALK</b>		15. MOTHER'S MAIDEN NAME First <b>LAURA</b> Middle <b>V.</b> Last <b>DEVAUGH</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-28-6949</b>		17. INFORMANT <b>ELEANOR B. JONES</b>		Address <b>SAME 21208</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>dissecting Aortic aneurysm of the ascending aorta</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>7/11/80</b> <b>18 Yr.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>October 10, 1978</b> , to <b>January 8, 1981</b> , that (I) <del>two</del> <b>one</b> last saw the deceased alive on <b>January 9, 1981</b> , and that in (my) <del>our</del> <b>my</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did</b> (did not) view the body after death.							
22b. SIGNATURE <b>Edwin L. Pierpont, M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/9/81</b>	
22d. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, MD</b>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-9-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. CO. MD.</b>	
24. FUNERAL DIRECTOR <b>NEWELL F.H.</b>				ADDRESS <b>1100 REISTERS TOWN RD.</b>		25a. REGD BY REGISTRAR <b>JAN 16 1981</b>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8100319		REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWARD BROWN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1-22-81</b>			2b. HOUR <b>4:51 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 01 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR IF UNDER 2 YRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>RANDALLSTOWN</b>		13d. STREET ADDRESS <b>3108 FAIRVIEW ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACK BROWN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESEBELLE PIBNKNEY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-07-9800</b>		17. INFORMANT ADDRESS <b>ANNIE BROWN 3108 FAIRVIEW ROAD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSELEOTIC HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>EMBOLISM</b> <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE POSSIBLE PULMONARY</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)						
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>1-15-81</b> , to <b>1-22-81</b> , that (I) (we) lost saw the deceased alive on <b>1-22-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-22-81</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ORLANDO B. CONNANAN, M.D.</b>		22e. ADDRESS <b>BEGH - RANDALLSTOWN, Md. 21133</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-27-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND NAT. MEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL MARYLAND</b>				
24. FUNERAL DIRECTOR NAME <b>ELIZABETH L. PHILLIPS</b>		ADDRESS <b>1721-27 N. MONROE ST.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 00320

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Florence L. BRANT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 22 81</b>		2b. HOUR <b>7<sup>34</sup> M</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 26, 1891</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>	
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13 Richmar Ct. Apt C</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>
13a. STATE <b>Ind</b>	13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>Owings Mills</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>13 Richmar Court C</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Eppers</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY JANE ?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-60-4091</b>	17. INFORMANT ADDRESS <b>Ethel Roszell 3533 Lynne Haven Dr BALTO. MD. 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>congestive Heart Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASUN</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>F.I.V. Syndrome.</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1110</b> , 19 <b>75</b> , to <b>1122</b> , 19 <b>81</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>1122</b> , 19 <b>81</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.				
22b. SIGNATURE <b>Robert I. Cooper</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/24/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert I. Cooper, MD</b>		22e. ADDRESS <b>8720 Red Pine Hill</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>JAN. 24, 1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW MEM. PARK</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville, Carroll Md.</b>	
24. FUNERAL DIRECTOR <b>H. Ehlhardt</b>		ADDRESS <b>Owings Mills Md</b>		25. DATE REG'D. BY REGISTRAR <b>JAN 25 1981</b>
26. SIGNATURE OF REGISTRAR <b>[Signature]</b>		27. SIGNATURE OF DECEASED <b>[Signature]</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8100321 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FLORENCE E. BUCKMAN</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1-3-81</b> 2b. HOUR <b>12 40 P.M.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87 yrs.</b> YRS. MONTHS DAYS HOURS MIN.
10. CITY OR TOWN OF DEATH <b>Rossville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.
13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Baltimore</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Boyle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Addie Wrightson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>141.09.4249</b>		17. INFORMANT ADDRESS <b>Joan Turner--Same as 13e</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular disease yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Anemia, severe organic Brain syndrome.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <b>5/10/1978</b> , to <b>1/3 1981</b> , that <del>we</del> (we) lost saw the deceased alive on <b>1/3 1981</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, <del>we</del> (we) (did) <del>not</del> view the body after death.					
22b. SIGNATURE <b>N. J. Tun</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>1/3/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHIN M. TUN</b>				22e. ADDRESS <b>2110 Pot Spring Road Md 21093.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/5/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore</b>		23e. COUNTY <b>Maryland</b>		23f. STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley Inc. Balto Md 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>Patricia McElreath</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 3 2 2	
1. FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH N BUCKSAR</b> <i>Elizabeth N Bucksar</i>		2a. DATE OF DEATH (MONTH DAY YEAR) <b>JANUARY 27, 1981</b>		2b. HOUR <b>10:00 P</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH (MONTH DAY YEAR) <b>11 10 1900</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. PLACE OF DEATH <b>Balto</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring Co.</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>Balto</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>NECKERMANN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>21206 BALTO.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-10-8664</b>		17. INFORMANT ADDRESS <b>RITA ROTH 24 FULLERTON HEIGHTS AVE MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNRESECTABLE PANCREATIC CARCINOMA</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE GASTROINTESTINAL BLEEDING</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital attended the deceased from <b>JAN 27</b> , 19 <b>81</b> to <b>JAN 27</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JAN 27</b> , 19 <b>81</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did not) view the body after death.					
22b. SIGNATURE <i>Pemy Chhim</i>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>01/27/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PEMY CHHIM</b>		22e. ADDRESS <b>7620 YORK RD. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 31, 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR NAME <b>Doppel Funeral Homes, Inc.</b> <b>DIPPEL FUNERAL HOMES INC.</b> ADDRESS <b>7110 Belair Road Baltimore, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Patricia Kelly</i>			

MEDICAL CERTIFICATION

100-443886-100

20 80000 151000 10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 1 0 0 3 2 3 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Helen G. Bullington								Jan. 21, 1981		10:30pm	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
F		W		Aug. 13, 1903				77		YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore, Md.		USA						Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital				Secretary		U. S. Govt.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN					
Md.				Baltimore		Towson					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
A. James Gilbert				Mary Gertrude Brady							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No				-		212 03 1930A		William R. Bullington 801 Southwick Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>Jan. 14, 1981</u> , to <u>Jan. 21, 1981</u> , that (we) lost saw the deceased alive on <u>Jan. 21, 1981</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did not view the body after death.											
22b. SIGNATURE <i>Nestor Carmona</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Jan. 22, 1981			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nestor Carmona, M.D.				22e. ADDRESS 6012 Harford Rd. Baltimore, Md. 21214							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY			
Burial		1/24/81		New Cathedral Cem.				Baltimore, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE RECORDED BY REG. NO. 25b. SIGNATURE							
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.				JAN 30 1981							

DATE: 10/11/61

TO: THE SECRETARY OF THE ARMY

FROM: THE CHIEF OF STAFF

SUBJECT: [Illegible]

1. [Illegible]

10/11/61  
[Illegible signature]

FOR  
STATE  
REGISTRAR

# DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

8 1 0 0 3 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frederick J. Buresch, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 10, 1981</b>		2b. HOUR <b>12:07 PM</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-15-1898</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FIREFIGHTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FIRE DEPT.</b>
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>FERDINAND BURESCH</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANTONIA PRONEK</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>215-24-4726T</b>		17. INFORMANT ADDRESS <b>Mrs. Matilda D. Buresch - 3126 Dubois Ave.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STROKES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE MONTH</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIAC DIS.</b>	<b>FIVE YRS.</b>
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PNEUMONITIS ASPIRATIONAL</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-1-</b> 19 <b>81</b> , to <b>1-10</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1-9</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Wm Carl Ebeling MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-10-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm Carl Ebeling MD</b>		22e. ADDRESS <b>7401 OSLER DR BALTO MD 21204</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1-14-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIAN NATIONAL</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR NAME <b>Harold Miller - 7527 Harford Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b>	25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00325		
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR
1. DECEASED NAME FIRST: Helen MIDDLE: Virginia LAST: Burns										ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 29 19 81		2b. HOUR 11:55
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10- 3- 24		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		2c. DATE PRONOUNCED DEAD 1 29 19 81		2d. HOUR 11:55		
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8432 Pulaski Hwy				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driven		12b. KIND OF BUSINESS OR INDUSTRY Balto. County				
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13b. STREET ADDRESS 3530 Buckboard Lane		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Nevins										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Bickford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212 204732		17. INFORMANT ADDRESS George M. Burns 3530 Buckboard Lane						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:15 PM 1/29 19 81				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by vehicle				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8432 Pulaski Hwy, Rosedale, Balto Co, MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE H. R. Shaw				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1/30/81				
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Baltimore, MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-2-81		23c. NAME OF CEMETERY OR CREMATORY Goodwin's Faith Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Crook Rosedale Funeral Home, 1211 Crook Ave.						25a. DATE RECEIVED BY REGISTRAR FEB 2 1981		25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 81 00326			
1. DECEASED NAME (TYPE OR PRINT) <b>Bertha Busch</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 18 81</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 30, 1891</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10 CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>AARON APATOFF</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-14-4966</b>		17 INFORMANT <b>MR. NORMAN BUSCH</b>			
				9000 SAMOSET RD., RANDALLSTOWN, MD 21133			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>5679</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Focal peritonitis</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION <b>1-11-81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Peritonitis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/10/81</b> , 19 <b>81</b> , to <b>1/18</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> , 19 <b>81</b> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Juan C. Ruffier MD</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/18/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN C. RUFFIER</b>				22e. ADDRESS <b>Old Court Rd Randallstown</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 20, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1981</b>			
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



NOTES

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Katherine (nmn) Cahall</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 6 81</b>		2b. HOUR MIN. <b>1:00P</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1915</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. Charles St. 21204</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Elect. Tech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>electronics</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Adcock</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann Branham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-14-8460</b>		17. INFORMANT ADDRESS <b>Charles T. Cahall, Abingdon, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Failure</b> <b>1830</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Cancer of the Ovaries</b> (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/15</b> , 19 <b>80</b> , to <b>1/6</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1/6</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 9, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>JAN 8 1981</b>		23f. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard K. McComas III, Abingdon, Md.</b>					

(M)

1981 JAN 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8100328	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>Marion G. Cairns</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>January 6, 1981</b>			2b. HOUR M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 9, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>			MD		
10. CITY OR TOWN OF DEATH <b>Lutherville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>37 Tenbury Rd.</b>				12a. USUAL OCCUPATION (NATURE OF WORK FOR MOST OF WORKING LIFE) <b>Admin. Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>37 Tenbury Rd. 21093</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Z. Cairns</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel E. Campbell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215-09-1477A</b>		17. INFORMANT <b>2940 S Tipperary Drive</b> <b>Grace E. Cairns, Tallahassee, Fla. 32308</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Superior Vena Caval Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Squamous Cell Ca. (L) Upper lobe lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <b>1629</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>18 mo.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>79</b> , to <b>Jan 6</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Nov 5</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. Wayland Eure, Jr. MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/7/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Wayland Eure, Jr. M.D.</b>						22e. ADDRESS <b>1900 E. Northern Parkway, Terrace</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-12-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Wood Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Tallahassee, Florida</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Towson, Md. 21204</b>						25. DATE REC'D. BY REGISTRAR <b>JAN 9 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



Handwritten text, possibly a signature or date, appearing as "1915" and "1916" in a cursive script.

1915

Handwritten signature or initials at the bottom left.

1821 8 MAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 2 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FILBERT Douglas Caltrider			2a DATE OF DEATH MONTH DAY YEAR January 8 1981			2b HOUR 9:00 AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec 24 1904		6 AGE (IN YEARS LAST BIRTHDAY) 76		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Gamber, Md.		8b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore Towson MD.			
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c COUNTY 13d CITY OR TOWN Maryland Carroll Westminster									
14 FATHER'S NAME FIRST MIDDLE LAST Andrew J. Caltrider				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Knight					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-22-2135		17 INFORMANT Ranadown, Md. 21033 Wilbur V. Caltrider 3803 Brenbrook Drive					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ca. left kidney c metastases to lungs.</u> 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>Jan 6 1981</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE <u>MD J. Quinn</u>				22c DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d DATE SIGNED 1-8-81	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 1-11-81		23c NAME OF CEMETERY OR CREMATORY Providence		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Carroll Md.	
24 FUNERAL DIRECTOR NAME Cal Hotel				24b ADDRESS 254 East Main Street Westminster, Maryland 21157		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	

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Co. 1st Regt. 1st Div. 1st Corps

1-8-81  
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1-8-81



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EARNEST CRETE CAMPBELL, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 8, 1981</b>		2b. HOUR <b>10:51a</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 22 1922</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Checker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.M.</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Crete E. Campbell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evie E. Mays</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>234-22-0408</b>		17. INFORMANT <b>Gayla E. Campbell</b>		
				ADDRESS <b>8033 Del Haven Rd Balto. MD. 21222</b>		
18. CAUSE OF DEATH (Enter only one cause per line for local, and one for remote) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure, Septic Shock.</b> <b>5728</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 29, 1980</b> to <b>January 8, 1981</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 8, 1981</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr. DelMonte</b>		DEGREE <b>Dr. DelMonte</b>		22c. DATE SIGNED <b>1-8-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. DelMonte</b>		22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Mem. Gdn</b>		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b>		
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh Balto. MD.</b>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8100331	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		MIDDLE LAST <del>AMELIA</del> Veronica CAROZZA				2a. DATE OF DEATH		MONTH 1	DAY 16	YEAR 81	2b. HOUR 10 P.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 16, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPHS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 303 Notre Dame Lane					
14. FATHER'S NAME FIRST MIDDLE LAST Antonio M. Jorio				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine N. DiAmond							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No		16b. SOCIAL SECURITY NO. 218-54-3350		17. INFORMANT Ernest M. Carozza		ADDRESS 6001 N. Charles St. Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5858 IMMEDIATE CAUSE (a) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) <del>CHRONIC RENAL FAILURE</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <u>XIX</u> (this hospital) attended the deceased from <u>JANUARY 10, 1981</u> , to <u>JANUARY 16, 1981</u> that <u>X</u> (we) last saw the deceased alive on <u>JANUARY 16, 1981</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did) (not) view the body after death.											
22b. SIGNATURE D. S. Kalaria				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/16/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. S. KALARIA				22e. ADDRESS St Joseph's Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 19, 1980		23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co., Maryland					
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.				ADDRESS 6500 York Rd. Baltimore, Md.		25a. DATE RECEIVED BY REGISTRAR JAN 20 1981		25b. SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) CYRIL J. CASSIDY					2a. DATE OF DEATH MONTH DAY YEAR January 8, 1981					
2b. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		2b. HOUR 8:30 A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10-C Choate Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Credit Man		12b. KIND OF BUSINESS OR INDUSTRY Gas & Oil		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10-C Choate Court	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph J. Cassidy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Kirwan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No			16b. SOCIAL SECURITY NO. 212 09 0205		17. INFORMANT Marguerite Z. Cassidy			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Lung -</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>78</u> , to <u>8 Jan</u> , 19 <u>81</u> , that (I) (we) lost <u>Dec</u> <u>81</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Lawrence Boas</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>JAN 10, 1981</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawrence Boas, M.D.					22e. ADDRESS 50 Scott Adam Road Cockeysville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE 1/12/81		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR JAN 12, 1981				
25b. REGISTRAR'S SIGNATURE <u>John H. Brady</u>										



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Dr. Lawrence B. D. M.

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Henry W. Jenkins & Sons Co.

4005 York Road, Baltimore, Md. 21212

Belts, County, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		JEROME J. CASS IZZI		1 16 '81		12:10A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		WHITE		10 9 1910		70		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
ITALY		U.S.A.				BALTIMORE COUNTY		MD. Wyeth Pharm.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		GBMC-6701 N. CHARLES ST.		Retired					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3509 Shannon Dr-21213	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		214-03-0131		Mrs. THERESA Cassizzi - SAME	
Joseph Cassizzi		Donata Fino		No					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST									
1901 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CANCER LEFT ORBIT									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from 12/17 1980, to 1/16 1981, that (I) (we) lost saw the deceased die on 1/16 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.									
22b. SIGNATURE									
DEGREE									
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
22c. DATE SIGNED 1/16/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
POLLACCHI L.V.'s GBMC-6701 N. CHARLES ST.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		1/19/81		Gardens of Faith		Balto.		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS		JAN 19 1981							
ZANNINO Funeral Home-263 S. Conkling									

MEDICAL CERTIFICATION

29

2633 BP



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*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8100334			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1 21 81 5:40 PM			
I. DECEASED NAME FIRST MIDDLE LAST Clarence Creston Cathcart				2b. HOUR			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 29 1899		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chapel Hill Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Accountant		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Nelson Cathcart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Koffemberger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. - (IF YES, GIVE WAR OR DATES) 215-10-3807		17. INFORMANT ADDRESS Mr. Creston Lyle Cathcart 36 Holly Rd., Severna Park, MD 21146			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC C.V. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN. YEARS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) PARKINSON'S DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:40 A.M. 1 2 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/15/77, 19____, to 1/21, 1981, that (I) (we) lost saw the deceased alive on 1/21, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Martin E. Strober				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN E. STROBER				22e. ADDRESS 51 HANOVER ROAD REGISTERSGOWN			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/24/81		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, P.A.				25a. DATE REC'D. BY REGISTRAR JAN 23 1981		25b. REGISTRAR'S SIGNATURE	
8728 Liberty Rd., Randallstown, MD 21133							

POST & SMALL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81

00335

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna CESKY			2a. DATE OF DEATH MONTH DAY YEAR January 9, 1981		2b. HOUR 4:20 a.m.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 26, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czech.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bouda			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Broz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -		16b. SOCIAL SECURITY NO. 215-09-2303		17. INFORMANT ADDRESS Joseph J. Krejci, son, same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Lower Lobe Pneumonia 4810 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 8, 1981, to January 9, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 9, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE Enrique Hernandez M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/9/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Enrique Hernandez M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 1/12/81	23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR JAN 13 1981	
				25b. REGISTRAR'S SIGNATURE R. J. H. H. H.	

BP

FROM E. EMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

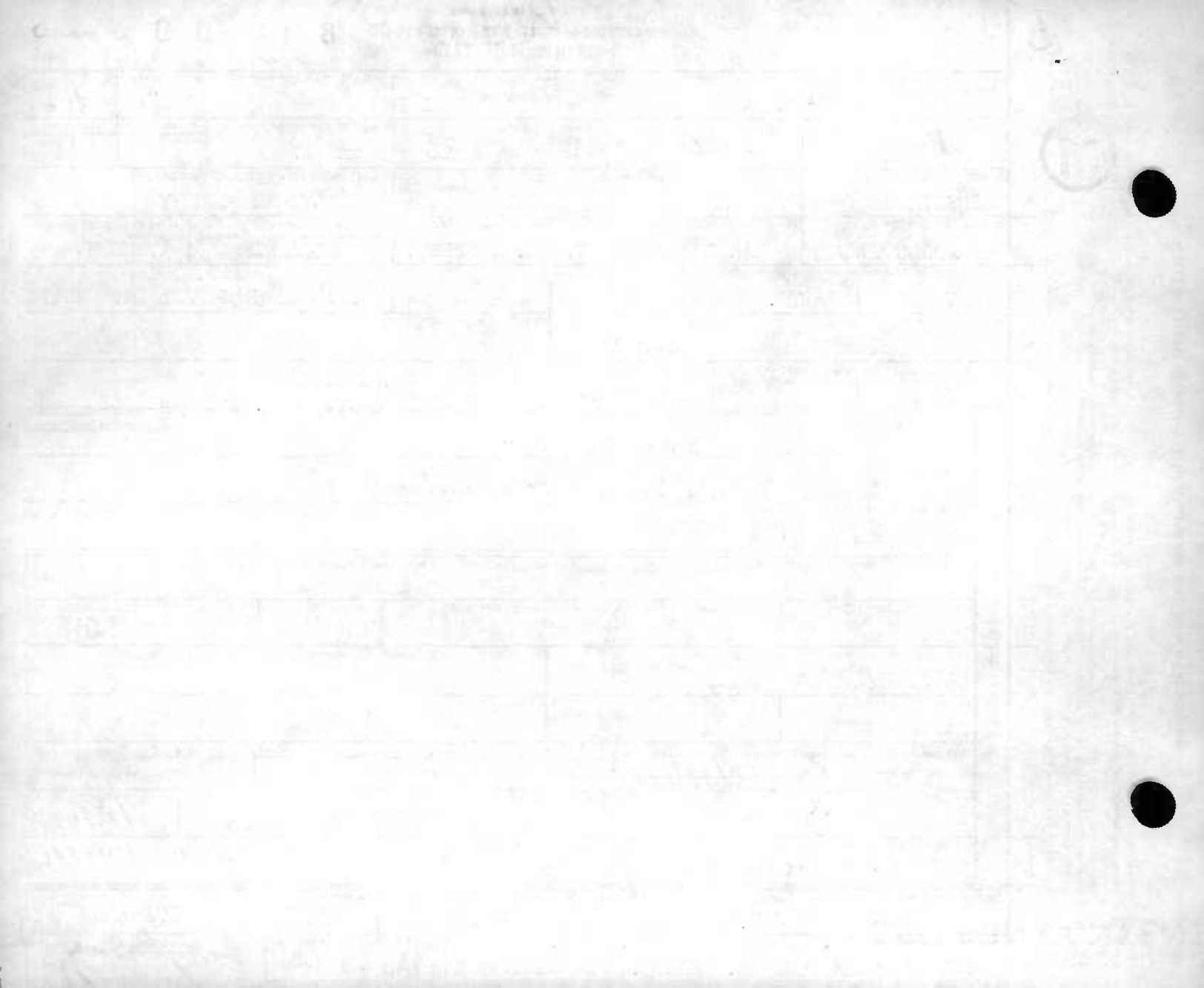
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LENA LENA			FIRST MIDDLE LAST CHAIKIN CHAIKIN			2a. DATE OF DEATH MONTH DAY YEAR 1 12 1981		2b. HOUR 1:35 AM			
3. SEX F. EAMLE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 31 93		6. AGE (IN YEARS LAST BIRTHDAY) 88 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						APT. 101					
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8507 GLENN MICHAEL LA. #21133			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-74-4470		17. INFORMANT ADDRESS SOL CHAIKIN 3509 FOXCLIFFE CT., APT. 101 #21133							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brainstem Stroke</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>1/12/1981</u> , to <u>1/12/1981</u> , that (I) (we) lost saw the deceased alive on <u>1/12/1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/12/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SRINIVAS				22e. ADDRESS BALTIMORE COUNTY GEN HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 13, 1981		23c. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR JAN 14 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8100337	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST LORRAINE		MIDDLE CHALMERS		LAST		2a. DATE OF DEATH MONTH DAY YEAR 1 29 '81		2b. HOUR 1:40A <sub>M</sub>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 20 10		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Technician		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 501 W. Franklin St.			
14. FATHER'S NAME FIRST MIDDLE LAST Floyd Carroll Kinney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Lorraine Deacon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 065-16-9402		17. INFORMANT 2300 Harvard Ave. Lillian Kiesling, Camp Hill, Pa. 17011					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> 1579 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CARCINOMA OF PANCREAS</b> (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-13, 19 80, to 1-29, 19 81, that (I) (we) lost saw the deceased alive on 1-29, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Michael B. Grieco M.D.</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-29-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL B. GRIECO, M.D.				22e. ADDRESS GBMC-6701 N. CHARLES ST.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 1/29/81		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS ANATOMY BOARD OF MD. BALT., MD.						25a. DATE REC'D. BY REGISTRAR FEB 11 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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1-29-81

1-29-81

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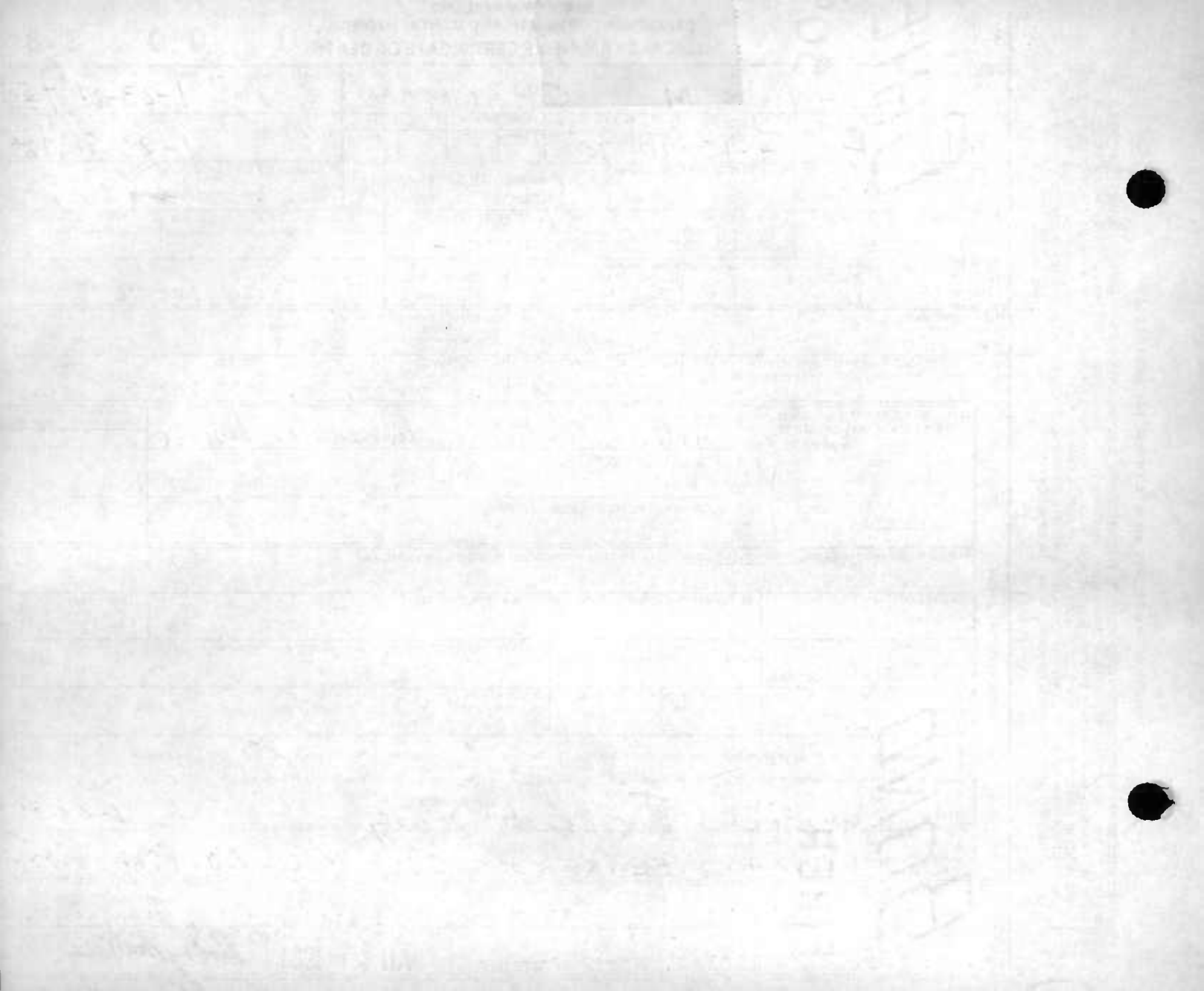
REMOVED

1-29-81

1-29-81

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00338			
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN M CHAPMAN</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>1-23-81</b>		2b. HOUR <b>7:55 AM</b>	
3. SEX <b>M</b>		4. RACE <b>B.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-15-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>4412 Belview Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Antonio Chapman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Mears</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>227-12-6545</b>				17. INFORMANT <b>J. Chapman, Jr. 4412 Belview Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4092 Arteriosclerotic Cardiovascular Disease</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>CONRADO FERRERO</b> M.D. (SPECIFY) <b>Deputy</b>										DATE SIGNED <b>1-23-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>CONRADO FERRERO</b>										ADDRESS <b>5550 Balls Blk. N. Pike 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/26/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Campbell Chapel Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Springfield, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Deputy Registrar</b>					

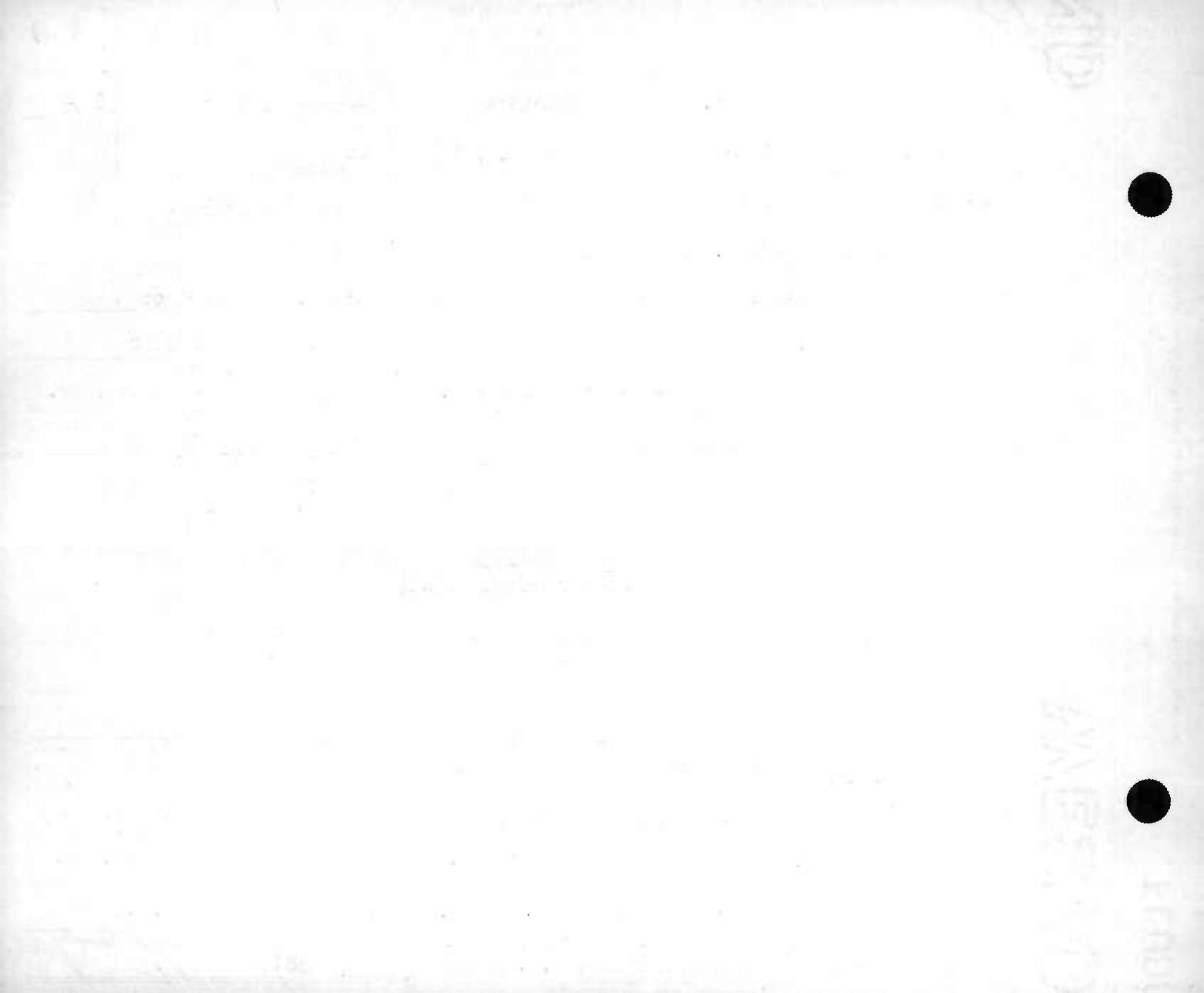


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8100339			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH E. CHARLTON				2a. DATE OF DEATH MONTH DAY YEAR January 8, 1981		2b. HOUR 2 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 27, 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 413 G. Wheaton Place		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Catonsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 413 G. Wheaton Place	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph M. Warfield				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella V. Glocker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-34-3587		17. INFORMANT ADDRESS Ellicott City, Md. 21043 Lewis W. Charlton, 10221 Green Clover Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) 4100 (b) Recurrent myocardial infarction (c) 2 hrs. 10 yrs. (d) Arterio Sclerosis Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis							
19a. DATE OF OPERATION home		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1972, to July 8, 1981, that (I) (yes) last saw the deceased alive on Jan. 5, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Earl L. Chambers MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/9/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Earl L. Chambers				22e. ADDRESS 100 W. Cold Spring Lane, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/10/81		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville, P.A. 21228				25a. DATE REC'D. BY REGISTRAR JAN 13 1981		25b. REGISTRAR'S SIGNATURE	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00340	
1. DECEASED NAME (TYPE OR PRINT) <b>Arthur C. Chausfaureax</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 25 19 81</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5/13/24</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>56</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 26 19 81</b>		2d. HOUR <b>2:15 P M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holiday Inn, Loch Raven &amp; Joppa Rds.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Brakeman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Loch Raven &amp; Holiday Inn, Joppa Roads</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Armand Hugo Chausfaureax</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II A212 30 2116</b>		17. INFORMANT ADDRESS <b>Records - Railroad, Balto., Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) M.D. <b>Assistant</b>				DATE SIGNED <b>1/27/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Central Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick County, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Herry W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur H. Brady</b>			

MEDICAL CERTIFICATION



50% COTTON FIBER

Yes WW II Acts 20 2118 Records - Railroad, Balto., Md.  
Armand Hugo Chulavarez Unknown  
Maryland Baltimore Townson  
Missouri U.S.A.  
Baltimore

Burial Henry W. Jenkins & Sons Co.  
2521 S. York Road Balto., Md. 21212  
Central Cemetery Frederick County, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
<div style="text-align: right;">8 1 0 0 3 4 1</div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b>            REG. NO.         </div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LIDA Elizabeth CHENWORTH</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1/14/81</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 29 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		7b. IF UNDER 1 YEAR MONTHS DAYS 7c. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Phoenix</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2 Blenfield Court, Phoenix</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <b>Md. Balto. Phoenix</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2 Blenfield Court, Phoenix</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harvey S. Armacost</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bernice Stiffler</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No ---</b>					16b. SOCIAL SECURITY NO. <b>219 24 6486</b>		17. INFORMANT ADDRESS <b>Mr. George H. Chenworth, 2 Blenfield Ct.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric Carcinoma</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION <b>1-25-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gastric carcinoma</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>1-2-80</b> , 19 <b>81</b> , to <b>1/14</b> , 19 <b>81</b> , that (I) <del>XXXX</del> saw the deceased alive on <b>1/14</b> , 19 <b>81</b> , and that in (my) <del>XXXX</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>XXXX</del> did (did not) view the body after death.									
22b. SIGNATURE <b>Rolando Vieta</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/14/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rolando Vieta</b>					22e. ADDRESS <b>11 E. Chestnut Hill La. Reisterstown, Md. 21136</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b> ADDRESS <b>10 W. Padonia Rd.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Rita McCreedy</b>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00342		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wanda Cherry										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1 29 81		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR JAN. 28, 1957		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 29 81		2d. HOUR 6:35	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY COUNTY MD					
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1015 D Old Eastern Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY NURSING				
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN REISTERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 269 SUNNYKING DR., EXT. #21136				
14. FATHER'S NAME FIRST MIDDLE LAST RAYMOND EDWARD PRICE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY LYNN PRESSMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT MR. COLEMAN PRESSMAN 269 SUNNYKING DR., EXTENDED #21136						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) <u>Narcotism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>H. Guard</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 1/30/81		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-1-81		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CONG.				23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215						25a. DATE REC'D. BY REGISTRAR FEB 4 1981		25b. REGISTRAR'S SIGNATURE <u>Robert M. Harty</u>				

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8100343

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Thelma L. Chester</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>JAN 14 1981</i>			2b. HOUR <i>6A</i> M	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JULY 29 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO Co</i> MD.	
10. CITY OR TOWN OF DEATH <i>Parkville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <i>3108 Acton Rd</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housekeeper</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		13a. STATE <i>MD</i>		13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>Parkville</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3108 Acton Rd</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Andrie Mitchell</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edith D. Summers</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OF UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212-03-0386P</i>		17. INFORMANT ADDRESS <i>FAMILY RECORDS</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4-100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>3-Recent acute myocardial ischemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>7-Parkinson's Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Less than 1 hour</i> <i>12/18/80 -</i> <i>to 1/9/81</i>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

*Diabetes Mellitus & Cardiac & Coronary Insufficiency*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/18/80</i> , 19 <i>81</i> , to <i>1/14</i> , 19 <i>81</i> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard J. Cohen M.D.</i>				DEGREE		22c. DATE SIGNED <i>1/14/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BERNARD J. COHEN M.D.</i>				22e. ADDRESS <i>The Maryland Opt - 3501 St. Paul St -</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>1-16-1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKWOOD</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>PARKVILLE BALTO. MD.</i>	
24. FUNERAL DIRECTOR NAME <i>EVANS FUNERAL CHAPEL</i> ADDRESS <i>8300 HARTFORD</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

*[Faint, illegible handwritten text covering the majority of the page]*



*[Handwritten signature or name]*

1891 J. S. K.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100344

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John B Clark</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 1 1981</b>			2b. HOUR <b>12:10 AM</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 17 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto Co</b> MD.			
10. CITY OR TOWN OF DEATH <b>CARNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9803 Hilltop Dr</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Advertising</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Text Mag</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>CARNEY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9803 Hilltop Dr</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Clark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE TIERNEY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-10-2599</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma Esophagus with</b> <b>1509</b> DUE TO, OR AS A CONSEQUENCE OF <b>metastatic disease of mediastinum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Moderately Severe Chronic Obstructive Pulmonary Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>Nov 25 1980</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Esophagus Cancer</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 19 80</b> to <b>Dec 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) do not view the body after death, so state.)									
22b. SIGNATURE <b>Frank T Kasik MD</b>				DEGREE				22c. DATE SIGNED <b>1/3/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK T KASIK MD</b>				22e. ADDRESS <b>9005 Harford Rd Balto Md 21234</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-3-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Fullerton</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Co MD</b>			
24. FUNERAL DIRECTOR NAME <b>EVANS FUNERAL CHAPEL 8800 Parkview Rd</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1981</b>		25b. REGISTRAR'S SIGNATURE <b>History McLeamy</b>			

BP

John B. Clark

June 1 1981

June 17 1981

81

the center of the world  
the center of the world

the center of the world  
the center of the world

Frank Jones

Apr 18

X

1/3/81

Good Harbor Rd. Littleton, CO

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FORA  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Carl E. Clary</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/10/81</b>			2b. HOUR <b>4:20am</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 23, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6902 Petworth Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David William Clary</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Sloan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>060 03 2558</b>		17. INFORMANT ADDRESS <b>Mrs. Marjorie D. Clary 6902 Petworth Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> 7991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1/79</b> , 19 <b>81</b> , to <b>1/10</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/10</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>G.D. Hardy MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/10/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY HARVEY</b>						22e. ADDRESS <b>1701 W PRATT ST BALT</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/10/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baldwinsville, N. Y.</b>			
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME, INC.</b>						ADDRESS <b>6500 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1981</b>		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

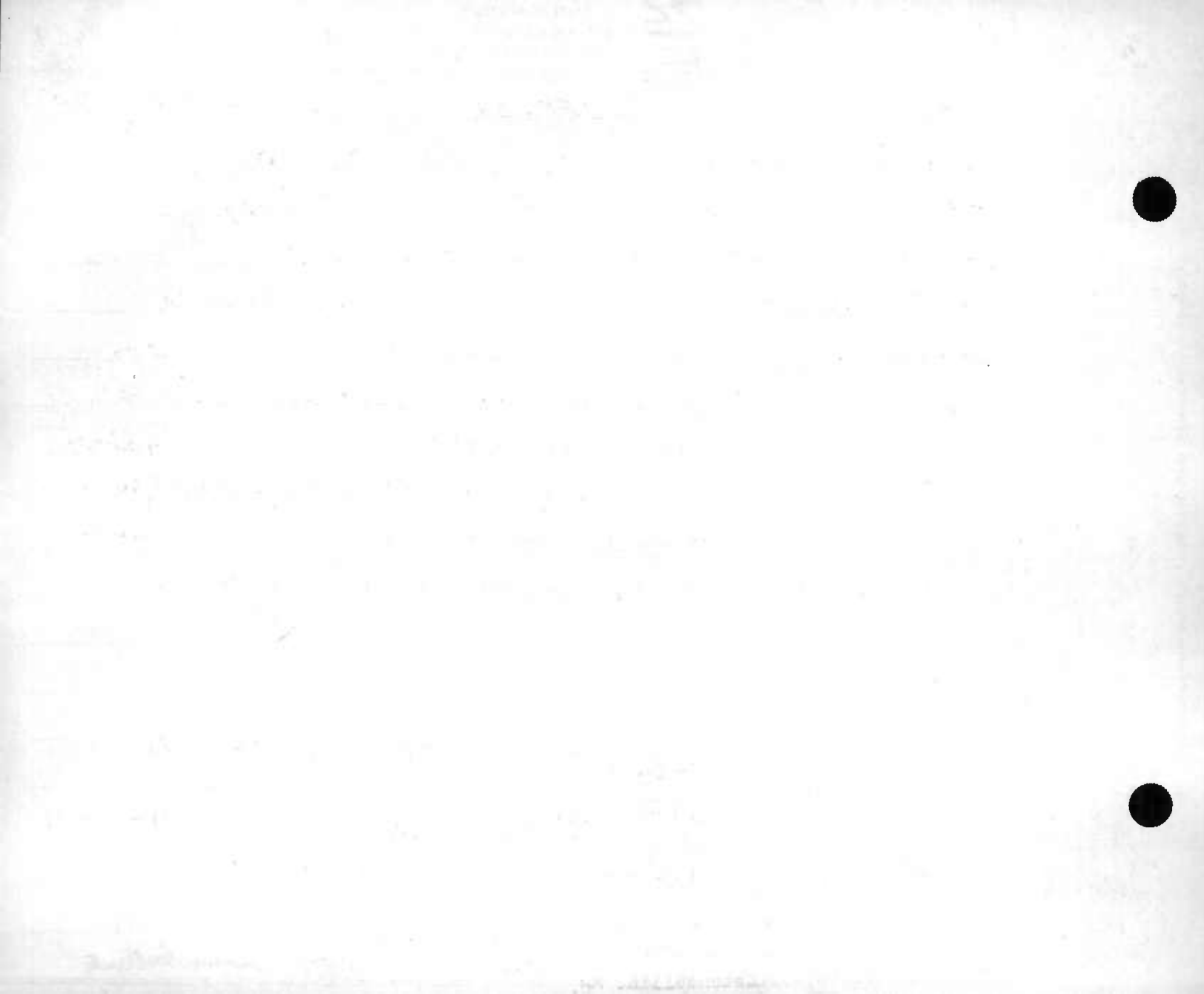
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 4 6

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <b>BESSIE CLEFFLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-81</b>			2b. HOUR <b>9P</b> M				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/7/85</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. County</b> MD				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHANGRI LA Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1822 PALO CA</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES KEYS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REGINA KEYS</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>220-22-6876</b>				17. INFORMANT <b>CHARLES CLEFFLER</b>				ADDRESS <b>Balto. Md. 21227</b> <b>1822 PALO CA</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable CHF</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD (Chronic Atrial Fib + LBBB) years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Basal Cell CA of L. Nasolabial region</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5-23-1977</b> to <b>1-17-1981</b> , that (I) (we) last saw the deceased alive on <b>1-17-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Esar Valle Caveno</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1-18-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESAR VALLE CAVENO</b>				22e. ADDRESS <b>5310 Old Pt. Rd</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/21/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>			
24. FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>				
1 630 Edmondson Ave Catonsville, Md.										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

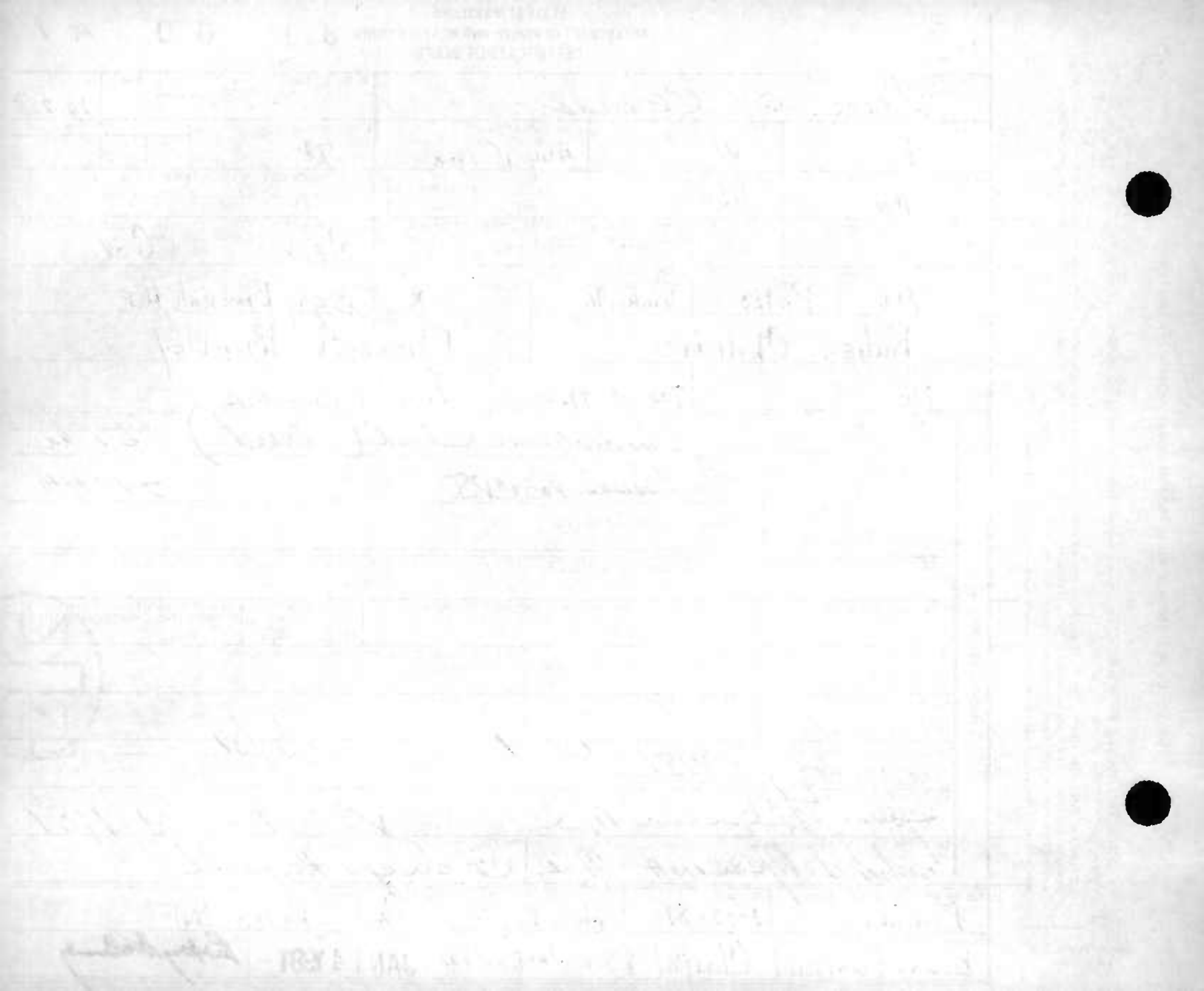
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Grace E. Clemens</i>			2a. DATE OF DEATH MONTH DAY YEAR Jan. 9, 1981			2b. HOUR 10:20 AM				
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug 15 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Joseph Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CLERK</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Gov.</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Balto</i> 13c. CITY OR TOWN <i>Parkville</i> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>2909 Emerald Ave</i>										
14. FATHER'S NAME <i>Ruben Chilouress</i>					15. MOTHER'S MAIDEN NAME <i>Elizabeth BRAULEY</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>705-05-4922</i>		17. INFORMANT <i>Family RECORDS</i>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Shock (Heart)</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Aneurysm</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hr</i> <i>&gt; 1 day</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>1/9/81</i> to <i>1/9/81</i> , 19____, that (1) (we) last saw the deceased alive on <i>1/9/81</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) see the body after death.										
22b. SIGNATURE <i>John J. Messina M.D.</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/9/81</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John J. Messina M.D.</i>					22e. ADDRESS <i>St. Joseph Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>1-12-81</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Redeemer</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto MD</i>			
24. FUNERAL DIRECTOR NAME <i>Evans Funeral Chapel</i>					ADDRESS <i>8800 Nantuxo Rd</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 14 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 4 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Braxie Ellen Cobun</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 9, 1981</i>		2b. HOUR <i>3:32 AM</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 15, 1919</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Woodmoor</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3510 Rhom Rd. Woodmoor, Md. 21207</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Woodmoor</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3510 Rhom Rd. Woodmoor, Md. 21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Claude Ernest Hunt</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lora Murphy</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>				16b. SOCIAL SECURITY NO. <i>230-01-5173</i>		17. INFORMANT <i>Mr. Lloyd Cobun</i> ADDRESS <i>Cobun</i> <i>3510 Rhom Rd. Woodmoor, Md. 21207</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sute Myocardial Infarct</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden onset</i> <i>Yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>COPD + chr. Bronchitis; Diabetes; Nephrosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Stephen Margolis</i>				DEGREE ATTENDING <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> MEDICAL <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>1/9/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen Margolis</i>				22e. ADDRESS <i>10219 South Dolfield Road Owings Mills, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-12-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Morgantown Monogalia W. Va.</i>			
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, P.A.</i> ADDRESS <i>8728 Liberty Road Randallstown, Maryland 21133</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 13 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Loring Byers</i>			

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CLASSIFICATION: TOP SECRET



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 4 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SHARON S. COFFMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 16, 1981</b>			2b. HOUR <b>8:15a M</b>			
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 9, 1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner-Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>White Marsh</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Sindelar</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Harlen</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES) <b>-</b>		16b. SOCIAL SECURITY NO. <b>220 32 3466</b>		17. INFORMANT ADDRESS <b>Susan Sindelar 1511 Becklow Ave. 21220</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE INTRACEREBRAL HEMORRHAGE</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>H/O HYPERTENSION</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>January 15, 1981</b> , to <b>January 16, 1981</b> , that (I) (X) last saw the deceased alive on <b>January 16, 1981</b> , and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above. (If (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz))									

MEDICAL CERTIFICATION

1

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

24. FUNERAL DIRECTOR

Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.

25a. DATE REC'D BY REGISTRAR

JAN 20 1981

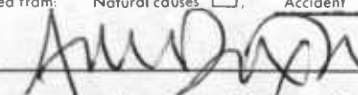
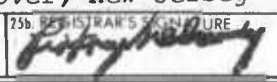
25b. REGISTRAR'S SIGNATURE

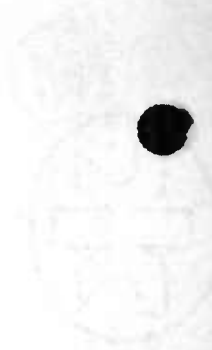


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00350	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERNARD J. COMPAGNONE</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>1 25 1981</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 1, 1958</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>22</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 25 1981</b>		2b. HOUR <b>6p</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>	
10. CITY OR TOWN OF DEATH <b>Fullerton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 695 east of Putty Hill Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR VARIOUS WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>New Jersey</b>				13b. COUNTY <b>Essex Fells</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>17 Hawthorne Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franco Compagnone</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anita Moreno</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>136-58-6026</b>		17. INFORMANT ADDRESS <b>Mr Franco Compagnone Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> 7 <b>8120</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR <b>5:53 P.M. 1-25- 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/auto collision.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 695 e. Putty Hill Ave., Balto. Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1-26-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/29/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>East Hanover, New Jersey</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b>		25b. REGISTRAR'S SIGNATURE 			



*[Faint, illegible handwritten text]*

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JAN 8 1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100351

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY M. CONRAD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 11 81</b>			2b. HOUR <b>2:40 P.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 2, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MED. CTR.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rush</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgeanna Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>G.B.M.C. Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LIVER FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>METASTATIC CARCINOMA OF COLON</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the Registrar) attended the deceased from <b>12/24</b> , 19 <b>80</b> , to <b>1/11</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) (not) view the body after death.							
22b. SIGNATURE <b>Apparao N.V. Vanguri</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>APPARAO N.V. VANGURI</b>				22e. ADDRESS <b>GREATER BALTIMORE MEDICAL CENTER 6701 N. CHARLES ST. TOWSON, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/15/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fishertown Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fishertown Bedford, Pa. 21204</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MacNabb Funeral Home Catonsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glenn Michael COOK			2a. DATE OF DEATH MONTH DAY YEAR January 1, 1981			2b. HOUR 10:35 a.m.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-12-1950		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harbor Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none			
13a. USUAL RESIDENCE (IF HOME AND HOME) OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION Ind.		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1106 W. Hamburg St. 21230					
14. FATHER'S NAME FIRST MIDDLE LAST Donald Franklin Cook				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy L. Greener							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -		17. INFORMANT Dorothy L. Cook - 1106 W. Hamburg St. 21230							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 3591 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Duchenne's Muscular Dystrophy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-30</u> 19 <u>80</u> , to <u>10-22</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>12-10</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE H. Newball						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-2-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold H. Newball						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-5-1981		23c. NAME OF CEMETERY OR CREMATORY Shadesbury Green			23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS John J. Comer - San Jac. 901 Jackson St.											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 5 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>IDA G. COOPER</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>2</b> YEAR <b>81</b>		2b. HOUR <b>4 25</b> AM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>17</b> YEAR <b>1894</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE <b>SCHERR</b> LAST <b>SCHERR</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MERA</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>162-26-5602</b>		17. INFORMANT ADDRESS <b>MRS. EVELYN SHOR</b> <b>37 STONEHENGE CIR., APT. 2 #21208</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>obstructive jaundice (cholelithiasis)</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-29-1980</b> to <b>1-2-1981</b> , that (I) (we) lost saw the deceased alive on <b>1-2-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Soonchul Hong</b>		DEGREE		22c. DATE SIGNED <b>1-2-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOONCHUL HONG</b>		22e. ADDRESS <b>Baltimore County General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 4, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
6010 REISTERSTOWN RD. BALTO, MD 21215					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8100354							
1a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
WILLIAM L. CRAIN				1-30-81				11:18 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		8 MONTH 1 DAY 29 YEAR		51 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
ILLINOIS		USA				BALT. COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
RANDALLSTOWN		BALTIMORE COUNTY GENERAL HOSP.				WHSE. MANAGER		Auto Supply	
13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. STREET ADDRESS			
Md. BALTIMORE				Finksburg		2303 Pheasant Run Drive			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
WILLIAM LONIS CRAIN				IVA CARUTH HAMPTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No.				330-22-0242		June Crain 1625 jackson lane Finksburg, Md. 21048			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Arteriosclerotic heart disease with cardiopulmonary arrest 2 weeks									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction 2 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) nephritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-14-1981 to 1-30-1981, that (I) (we) lost saw the deceased alive on 1-30-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
SOON CHU L HONG		Baltimore County General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Removal		1/31/81							
24. FUNERAL DIRECTOR NAME ADDRESS									
Anatomy Board Balto., Md.									



330-22-0242 June Crain Finksburg, Md. 21048

IVA CARUTH HAMPTON  
1622 Jackson Lane

2303 Pleasant Run Drive

WHEE. MANAGER

BALT. COUNTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8100355			
1. DECEASED NAME (TYPE OR PRINT) Morgan L. Crocker				2a. DATE OF DEATH MONTH DAY YEAR Jan, 15 1981				2b. HOUR 5:00 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Farmer			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Glen Arm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11213 Old Carriage Road			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel G. Crocker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Letitia Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I		17. INFORMANT ADDRESS Elizabeth G. Crocker Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LAS CVD - Sick Sinus Syndrome CHF.</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>2. Ch. Dise. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3. Depression</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (the hospital) attended the deceased from <u>Jan 14</u> 19 <u>75</u> to <u>Jan 15</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Jan 14</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE DONALD W. MINTER				DEGREE M.D.				22c. DATE SIGNED 1/15/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD W. MINTER				22e. ADDRESS 3009 EVERGREEN AVE BALTIMORE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 17, 1981		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JAN 16 1981		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL C. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8100356			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Compton N. Crook				January 15, 1981			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 14 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
10. CITY OR TOWN OF DEATH Phoenix		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2829 Merrymans Mill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Prof./Biology		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Phoenix				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Compton Ney Crook				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Mai Newby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 212-38-0406		17. INFORMANT ADDRESS Mrs. Crook, 2829 Merrymans Mill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 5150 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-7</u> , 19 <u>80</u> , to <u>1-15</u> , 19 <u>81</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>11-22</u> , 19 <u>80</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.							
22b. SIGNATURE <u>J.R. Norris</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1-15-81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Norris, M.D.				22e. ADDRESS 3421 Sweet Air Rd. Phoenix, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremated		23b. DATE 1/17/81		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) Martin D. Lawson				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 19 1981 <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8100357 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <i>James Henry Crouthamel</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>1-5-81</i>				2b. HOUR <i>9:05P M</i>		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>04 06 12</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Philadelphia, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD					
10 CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore Co. General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Owner- Service Station</i>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Reisterstown</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>13 Benwell Road. 21136</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Crouthamel</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emily Courter</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>212-07-3533</i>		17 INFORMANT <i>Reisterstown, Maryland 21136</i> <i>Mrs Etta G. Crouthamel, 13 Benwell Road.</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ca of Stomach</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bilateral pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>(GAM)</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>1-5-81</i> 19 <i>81</i> , to <i>1-5-81</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>1-5-1981</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. M. Shah</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>1-5-81</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. M. SHAH.</i>					22e. ADDRESS <i>B. C. G. H. RANDALLSTOWN, MD. Old Court Road 21284</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>01/09/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore, Md.</i>			
24 FUNERAL DIRECTOR'S NAME <i>8728 Liberty Road, Randallstown, Md. Loring Byers Funeral Directors P.A.</i>					25a. DATE REC'D. BY REGISTRAR <i>JAN 9 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Loring Byers</i>				

2000 2001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8100358	
1 DECEASED NAME (TYPE OR PRINT) MARIE V. CURLE		2a DATE OF DEATH MONTH DAY YEAR 1 28 81		2b HOUR 6:30 P.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 10 22 01		6 AGE (IN YEARS LAST BIRTHDAY) 79	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) France	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Arbutus	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1136 Regina Drive		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailoring		12b KIND OF BUSINESS OR INDUSTRY Lamb Brothers
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland		13c COUNTY Baltimore	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 1136 Regina Drive Balto. Md.	
14 FATHER'S NAME FIRST MIDDLE LAST Emile Strabach		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-03-4051		17 INFORMANT George W. Curle		17 ADDRESS 1136 Regina Drive Balto. Md.	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Supra Ventricular tachycardia</u>					
19a DATE OF OPERATION <u>1/24/81</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Supra Ventricular tachycardia</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>80</u>			
21c INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>212</u>		21e LOCATION STREET CITY OR TOWN COUNTY STATE <u>4001 WILKENS AVENUE, 21229</u>	
22a I certify that (I) (this hospital) attended the deceased from <u>1/24/81</u> 19 <u>80</u> to <u>1/28/81</u> 19 <u>81</u> that (I) (we) last saw the deceased alive on <u>1/24/81</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not see the body after death.)					
22b SIGNATURE <u>I. Earl Pass M.D.</u>		22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED <u>1/30/81</u>	
23a PHYSICIAN'S NAME (TYPE OR PRINT) I. EARL PASS, M.D.		23b ADDRESS 4001 WILKENS AVENUE, 21229			
23c BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d DATE 1/31/81		23e NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23f LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23g DATE REC'D. BY REGISTRAR JAN 30 1981			
24 FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25 REGISTRAR'S SIGNATURE <u>Anthony McHenry</u>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 5 9

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <b>KENNETH M. DANIEL</b>		2b. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 3 81</b>		2c. HOUR <b>7:00 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 27 1959</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>21</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto</b> MD.	
10. CITY OR TOWN OF DEATH <b>OWINGS MILLS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ROSEWOOD CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Daniel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Artis</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-78-4557</b>	
17. INFORMANT ADDRESS <b>Willie Daniel 249 N. Asquith</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>3229</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>SPASTIC QUADRIPLEGIA SEIZURE DISORDER</b> (c) <b>MENTAL RETARDATION</b> (d) <b>ENCEPHALOPATHY DUE TO MENINGITIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 29</b> , 19 <b>80</b> , to <b>JAN. 3</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>JAN. 3</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Josecito C. Ocampo</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-3-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEITO C. OCAMPO, M.D.</b>		22e. ADDRESS <b>ROSEWOOD CENTER OWINGS MILLS</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-81</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Leroy Dyett F.H. 4600 Liberty</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

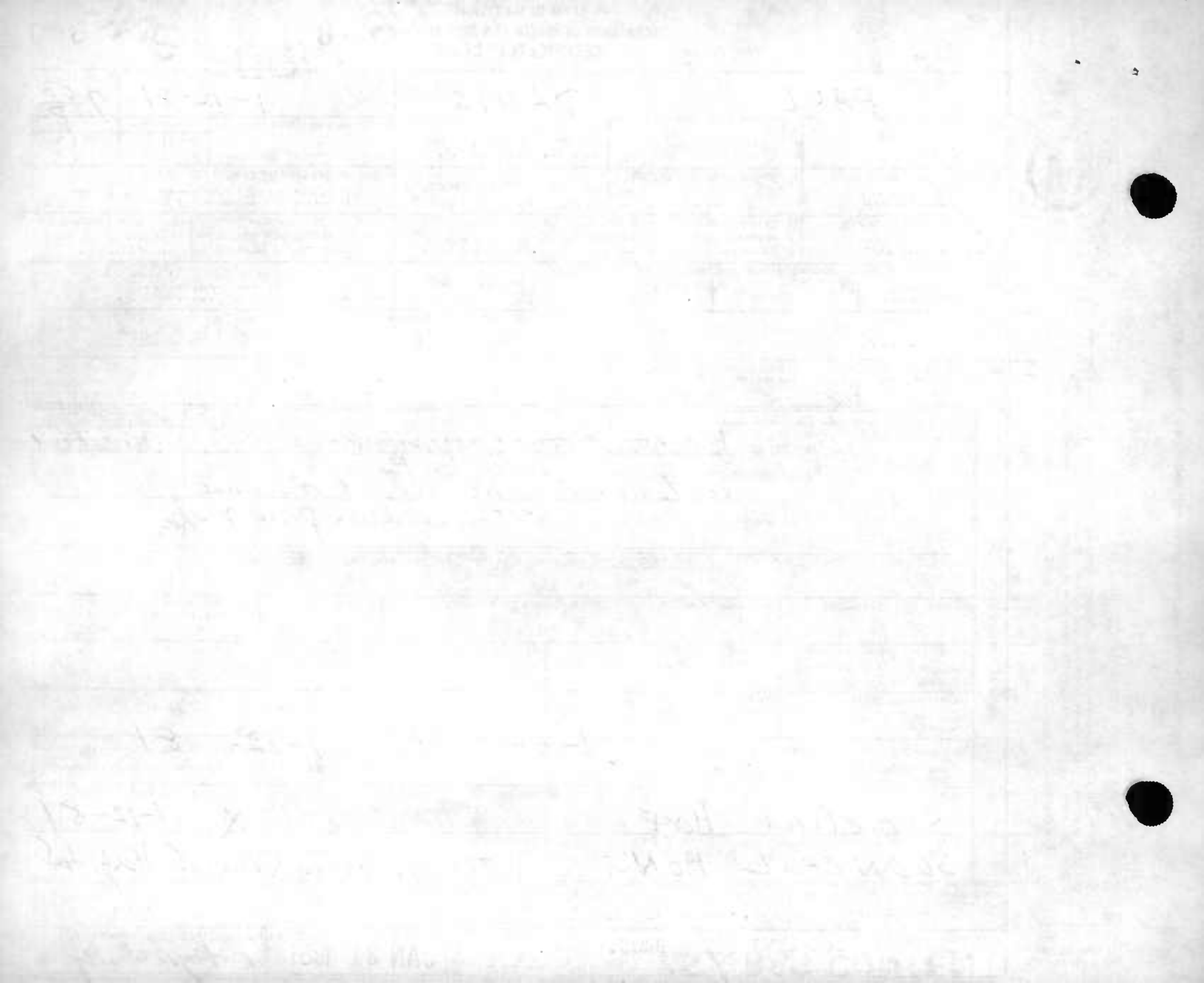
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				81 00360			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EARL DAVIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-12-81</b>		2b. HOUR MIN <b>7:03 P.M.</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APR. 16, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ENGINEER</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>FLORIDA</b>		13b. COUNTY <b>FT. LAUDERDALE</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>25 ISLE OF VENICE, APT. 1</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC DAVIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE LEVIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17. INFORMANT ADDRESS <b>MRS. ALTA S. DORNER</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4140</b> <b>Recurrent cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF <b>arteriosclerotic heart disease with cardiac pacemaker</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		33031		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-6-81</b> to <b>1-12-81</b> , that (I) (we) lost saw the deceased alive on <b>1-12-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Soonehul Hong</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-12-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOONEHUL HONG</b>				22e. ADDRESS <b>Baltimore County General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 15, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>	
6010 REISTERSTOWN RD. BALTO. MD. 21215							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				81 00361 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE DAVIS</b>				1-10-81				340P M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		10. IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
13a. STATE <b>Md</b>				13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cavassa Willis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Bramble</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219 18 9892A</b>		17. INFORMANT ADDRESS <b>William Davis 1704-28 Allegany Ave 21204</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>kidney pneumonia</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart diseases with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atrial fibrillation.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-6-81</b> , to <b>1-10-81</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. M. Shah</b>				DEGREE <b>M-D</b>				22c. DATE SIGNED <b>1-10-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. M. SHAH</b>				22e. ADDRESS <b>B. G. H., RANDALLSTOWN MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/13/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chestertown Kent Md</b>			
24. FUNERAL DIRECTOR NAME <b>BURGEE</b>				24b. ADDRESS <b>3631 FALLS RD</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1981</b>			
25b. REGISTRAR SIGNATURE <b>Ray H. H. H.</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Fred Charles Davis Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JUN 3, 1981</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6/30/1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91 yrs.</b>		7b. HOUR <b>6:15P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Houston, Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Forest Haven Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Editor &amp; Printer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Publishing</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3107 Normandy Woods Dr. 21043</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Rex</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Lovegrove</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW I WW II 063.09.6755</b>		17. INFORMANT ADDRESS <b>Fred C. Davis, Jr. 1427 Clairidge Rd Baltimore, Md. 21207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INFLUENZA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC BRAIN SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC C.V. DISEASE</b>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>5 YEARS</b> <b>YEARS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> , 19 <b>81</b> , to <b>1/3</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/2</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Irwin H. Moss, MD</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/4/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRWIN H. MOSS, MD</b>						22e. ADDRESS <b>11065 L. PATUENT PKWY COLUMBIA, MD 21044</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>1/5/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley Inc</b>						ADDRESS <b>Balto. Md. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1981</b>	
						25b. REGISTRAR'S SIGNATURE <b>Robert McLeod</b>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE L. DAVIS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Jan-11, 1981</b>		2b. HOUR <b>11:55 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 15 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city Co MD</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General Hosp</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>717 Lakeview Dr.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Barnes</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah E. Harris</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>240-03-8134</b>		17. INFORMANT ADDRESS <b>Dorothy Tyler 2508 Hollins St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Urinary tract infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan-9, 1981</b> , to <b>Jan-11, 1981</b> , that (I) (we) lost saw the deceased alive on <b>Jan-11, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sharon Pourmotabed</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>1-11-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GRASSEM POURMOTABED</b>		22e. ADDRESS <b>Balt. County Gen. Hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/15/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>			



Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2222.

#13e, 6552 2/11/81 bal

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 00364

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Marye S. Debuskey</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Jan 31 1981</i>			2b. HOUR <i>6:50 A.M.</i>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 15, 1885</i>		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA MARYKANE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEPT. MANAGER HOSCHILD KOHN		12b. INDUSTRY STORE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2601 Eutaw Place <del>2010 BROOKFIELD AVE.</del> #21217	
14. FATHER'S NAME FIRST MIDDLE LAST DOVE BAER SCHWARTZMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHIAH TOBA SHOCKET					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-22-6210A		17. INFORMANT ADDRESS MRS. CHARLOTTE MILLER 1611 WOODLING WAY #21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Gen. Anasarca</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Over</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. Stephen Margolis</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Stephen Margolis				22e. ADDRESS 10219 Jette Rd. Baltimore, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-1-81		23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR FEB 4 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8100365	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alberta Aleida Degele</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>01 05 81</b>		2b. HOUR <b>1:05P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 31 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care - Towson</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Overlea</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6009 Mannington Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William F Schultz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Aleida</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-22-1725</b>		17. INFORMANT ADDRESS <b>Dorothy Bresnick 6009 Mannington Ave</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Atherosclerotic cardiac vasculature</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myo</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Parkinsonism - Cerebral Infarcts - Dep. phrenia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>may yrs</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7-27-69</b> to <b>1-5-80</b> , that (we) last saw the deceased alive on <b>1-5-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John C. Hyle</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-6-80</b>			
22d. PHYSICIAN'S NAME (PLEASE PRINT) <b>Dr. John C. Hyle</b>				22e. ADDRESS <b>7527 Belair Road</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/8/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Baltimore Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Road</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy Bresnick</b>			

BP



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DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 6 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Helen H. De Ran</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>14</b> YEAR <b>81</b>			2b. HOUR <b>8:10A</b> M.					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>25</b> YEAR <b>09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. Charles St. 21204</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ass't Postmaster</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Pylesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1009 Old Pylesville Rd Pylesville, MD. 21132</b>			
14. FATHER'S NAME FIRST <b>David</b> MIDDLE <b>G.</b> LAST <b>Harry</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b> MIDDLE <b>Lanius</b> LAST <b>NATHAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-36-8307</b>		17. INFORMANT ADDRESS <b></b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>1890</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Cell Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 Minutes</b> <b>5 Months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>12/29</b> , 19 <b>80</b> , to <b>1/14</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/14</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Michael B. Grieco</i>				DEGREE				22c. DATE SIGNED <b>1/14/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael B. Grieco, M.D.</b>				22e. ADDRESS <b>6701 N. Charles St. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>1/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>											
25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1981</b>						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

BP

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
AIR MAIL

RECEIVED

JAN 10 1964

RECEIVED

JAN 10 1964

RECEIVED

JAN 10 1964

RECEIVED

JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 0 0 3 6 7	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Alfred</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1-9-81</b>		2b. HOUR <b>11 A M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 5, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Towson Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Street Inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>✓</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>524 N. Charles Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Di Domenico</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie Filicicchia</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Mrs. Margaret Castoro</b>		ADDRESS <b>Jarrettsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Dehydrated Well fed</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9 Dec 80</b> to <b>Jan 81</b> , that (I) (we) lost saw the deceased alive on <b>9 January 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Walter T. Kees</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9 January 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER T. KEES</b>				22e. ADDRESS <b>Monkton Md 21111</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 12, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b>				25b. REGISTRAR'S SIGNATURE <b>Patricia Kebrudy</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 3 6 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WALLACE EDWARD DIETRICH SR				2a. DATE OF DEATH MONTH DAY YEAR January 21, 1981				2b. HOUR 12:40pm			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11/5/94		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY MAIL ROAD			
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 210 DORELL RD			
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT DIETRICH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. UNK		17. INFORMANT THELMA DIETRICH				ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular Accident; Cerebrovascular Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <u>Atherosclerotic Cardiovascular Disease; Peptic Ulcer Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>January 17</u> , 19 <u>81</u> , to <u>January 21</u> , 19 <u>81</u> , that (I) ( <input checked="" type="checkbox"/> ) lost saw the deceased alive on <u>January 21</u> , 19 <u>81</u> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) ( <input type="checkbox"/> ) did not view the body after death.											
22b. SIGNATURE <i>N. Gauhar</i>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Gauhar				22e. ADDRESS 9000 Franklin Square Drive 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/24/81		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.					
24. FUNERAL DIRECTOR NAME J.L. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR JAN 26 1981		25b. REGISTRAR'S SIGNATURE <i>Patricia McCready</i>			





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 0 3 6 9			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE S. DOEMLING</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>31</b> YEAR <b>81</b>		2b. HOUR <b>8:55</b> <sup>A</sup> <sub>M</sub>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>9</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NORTH SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTO. MEDICAL CTR.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>18912 Falls Road 21074</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Spamer</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth M.</b> MIDDLE <b>Ludloff</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-16-3098</b> <b>216-01-42528</b>		17. INFORMANT ADDRESS <b>Hampstead, Md.</b> <b>Anthony M. Doemling - 18912 Falls Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4960</b>						DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> <b>2 WEEKS</b>	
						DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b> <b>30 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> , 19 <b>81</b> , to <b>1/31/</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William J. Oktavec MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/31/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. W. OKTAVEC</b>				22e. ADDRESS <b>GREATER BALTO. MEDICAL CTR.</b> <b>6701 N. CHARLES ST. TOWSON MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-3-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middle River Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1981</b>		25b. <b>John C. Miller</b>	



RECEIVED  
FEBRUARY 1961  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

NEW YORK 100-100000-1000  
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8100370			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ETHEL E. DORSEY								1 12 81					8:25 <sup>A</sup>
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		BLACK		Feb. 14, 1903		77		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Baltimore Co.						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Randallstown		Balto. Co. Hospital		Homemaker		Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Balto		Randallstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8527 Winands Rd.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
MORRIS		JORDAN		No		219 92 5807		Jarrett Dorsey		Randallstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardio Respiratory failure													
1539 DUE TO, OR AS A CONSEQUENCE OF													
(b) Carcinomatosis													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Carcinoma of Colon													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-12-81, 1981, to 1-12-81, 1981, that (I) (we) lost saw the deceased alive on 1-12-81, 1981, and that in (my) (our) apin death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.													
22b. SIGNATURE		DEGREE				22c. DATE SIGNED							
						1-12-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
S.H. ASHRAU		90 BCHA. OLD COURTS. RANDALLSTOWN											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		1-16-81		St. Charles Cemetery		Tikewille Balto. Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm W. Haight		Lylesville, Md.		JAN 20 1981									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 OF THIS FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 72 HOUR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (S))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <b>KATHRYN EMILY DOUGLAS</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1/12 1981		2b. HOUR 4:30 A.M.	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 18 1912</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>68 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>1 12</b>	IF UNDER 24 HRS. HOURS MIN. <b>1 12</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Middle River</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6719 Harewood Park Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Middle River</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert W. Peters</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Reba G. Kuhn</b>		16. SOCIAL SECURITY NO. <b>207-07-8981</b>	
17. INFORMANT <b>Frank E. Douglas-Balto. MD. 21220</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>4100</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Chronic Rheumatoid arthritis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>K.S. Ahluwalia</b>		TITLE (SPECIFY) <b>Regent</b>		DATE SIGNED <b>1/12/81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>K.S. AHLUWALIA</b>		ADDRESS <b>2112 Dundalk Ave Balt 21222</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Kathy Kuhn</b>	
7922 Wise Avenue		Dundalk, MD. 21222		Baltimore, Maryland	

1-1-50

RECEIVED  
JAN 1 1950

TO THE DIRECTOR  
U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

FROM THE  
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 0 3 7 2			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
RICHARD DOUGLAS				1 5 '81 11:15P			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		Sept. 28, 1908		72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Canada		USA				BALT MORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		GBMC-6701 N. CHARLES ST.		Horseman			
13a. STATE				13b. CITY OR TOWN			
Maryland				Baltimore			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Towson				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Richard Douglas				Margaret Dunlea			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes				WW II		Mrs. Patricia J. Douglas same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Strokes.</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-03</u> 19 <u>80</u> , to <u>1-5</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1-5</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Kamal Dyal-Dottin</u>				DEGREE <u>MBBS</u>		22c. DATE SIGNED <u>1/5/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>K. DYAL-DOTTIN, M.D.</u>				22e. ADDRESS <u>GBMC-6701 N. CHARLES ST.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/9/81		Dulaney Valley Cem.		Baltimore Maryland	
24. FUNERAL DIRECTOR NAME <u>Ruck Towson Funeral Home, Inc.</u>				ADDRESS <u>1050 York Road</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 7 1981</u>	
						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MALE

WHITE

DOUGLAS

RICHARD

1 2 201 11:15

ON 20

BALTIMORE COUNTY

TOWSON

68NC-2701 N. CHARLES ST

68NC-2701 N. CHARLES ST

BALTIMORE COUNTY

100-100

100-100

100-100

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OSGROVE, ALFRED

X

10

11-2

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12-02

18

1-7

---

68NC-2701 N. CHARLES ST

X 100-100

100-100

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8100373			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET THELMA DOWNEY				2a DATE OF DEATH MONTH DAY YEAR January 16, 1981			2b HOUR 6:35a M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a STATE Maryland	13b COUNTY Baltimore	13c CITY OR TOWN 21239	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 909 Overbrook Road 21239			
14 FATHER'S NAME FIRST MIDDLE LAST George D. Ebbert Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Ora Grimes					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 705-14-1381		17 INFORMANT ADDRESS 21218 Gordon B. Downey 525 E. 38th. Street			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Complete Cardio-pulmonary Failure</u> 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). <u>Upper Gastrointestinal Bleeding</u> (c). <u>Metastatic Carcinoma of Stomach</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 13</u> , 19 <u>81</u> , to <u>January 16</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 16</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>J. E. Allen</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/16/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JENAN AL-MUFTI				22e ADDRESS 9000 Franklin Square Drive 21237			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 19, '81		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., Maryland	
24 FUNERAL DIRECTOR NAME William E. Johnson				24b ADDRESS 8521 Loch Raven Blvd.		25a DATE REC'D. BY REGISTRAR JAN 19 1981	
				25b. REGISTRAR'S SIGNATURE <i>John A. Roberts</i>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.BP  
DHMH-16 25M  
(VRA 15, 4) 1/791 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANTHONY DRANKIEWICZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 18 1981</b>		2b. HOUR <b>M</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>MAY 30 1898</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE Co. MD.</b>		
10 CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH'S HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>730 S. POTOMAC ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BARTHOLOMEW DRANKIEWICZ</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE ?</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213 36 0630</b>	17. INFORMANT ADDRESS <b>ROBT. DRANKIEWICZ SAME</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **C.V.A.**4292  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ESPEUD.**

DUE TO, OR AS A CONSEQUENCE OF

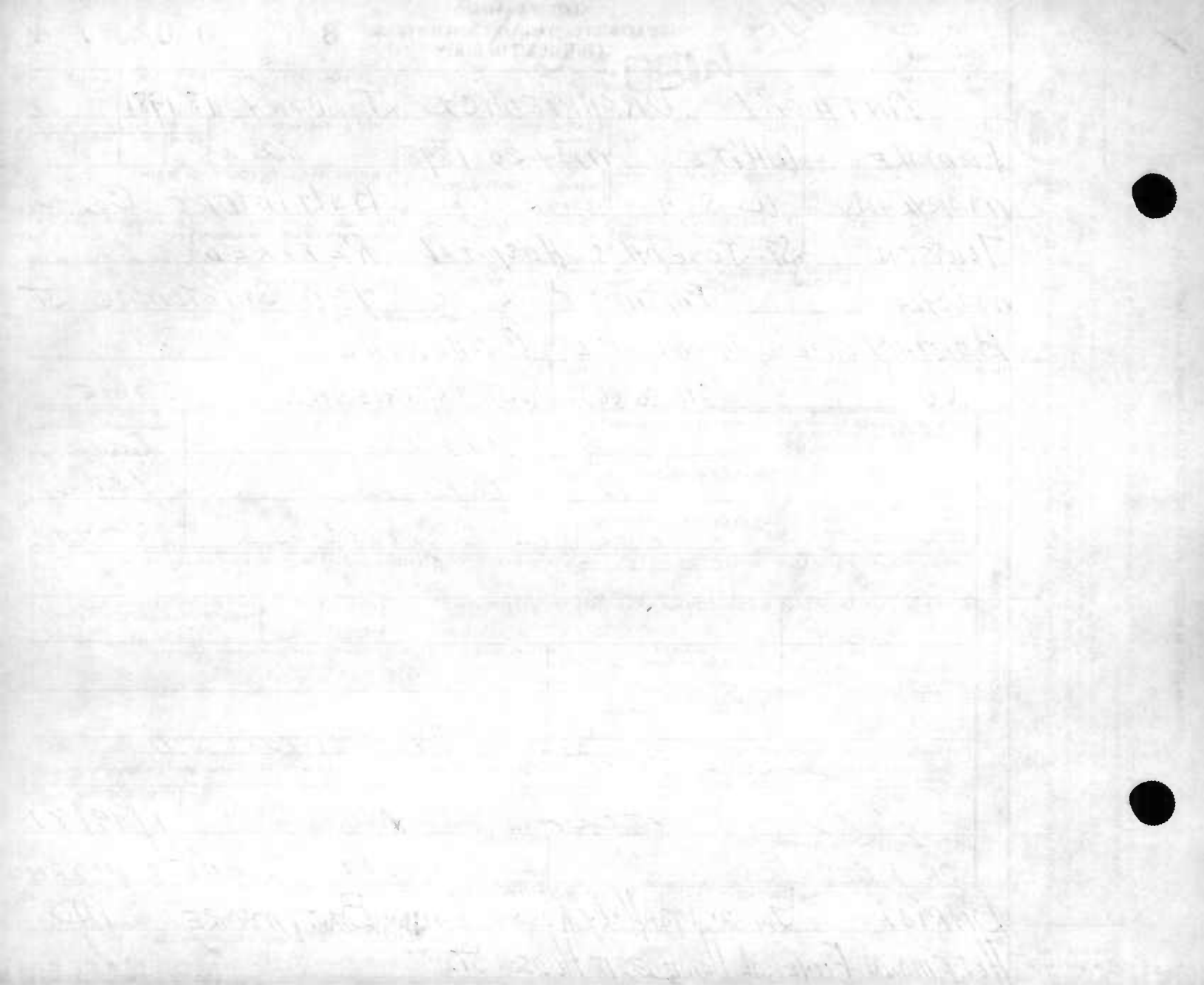
(c) **Slow Synchism**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**Days****Year****Days**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-29</b> 19 <b>80</b> , to <b>1-12-</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1-12-</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (saw) (did not) view the body after death			
22b. SIGNATURE <b>DR. R.E. COCCO</b>	DEGREE <b>MD</b>	22c. DATE SIGNED <b>1/19/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. R.E. COCCO</b>	22e. ADDRESS <b>20 E. EAGER ST., BALTO. MD. 21201</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>JAN. 21, 1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>
24. FUNERAL DIRECTOR NAME <b>HOFFMANN FUNERAL HOME</b>	ADDRESS <b>3218 HUDSON ST.</b>	25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified for a post-mortem examination.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100375

FOR  
STATE  
REGISTRAR XC 07 147 220

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>GEORGE William DRAPER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JANUARY 30, 1981</b>		2b HOUR <b>9:20p M</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>MAY 23, 1924</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>V.A. MEDICAL CENTER</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BLDG. MAINTENANCE</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Y.M.C.A.</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b>	13b COUNTY <b>BALTIMORE</b>	13c CITY OR TOWN <b>Towson</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS <b>668 RIORDAN TERRACE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Draper</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen XMMX Neno</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	16b SOCIAL SECURITY NO. <b>WW II 302 14 7240</b>	17 INFORMANT ADDRESS <b>CLIN. RECDS. VAMC FORT HOWARD, MARYLAND</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>  4110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE WITH CORONARY INSUFFICIENCY</b> (c) <b>BRAINS DAMAGE POST PREVIOUS C P R</b>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>  <b>YEARS</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (this hospital) attended the deceased from <b>9/23</b> 19 <b>74</b> to <b>1/30</b> 19 <b>81</b> , that (we) lost saw the deceased alive on <b>1/30</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>R. Reider</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>1/31/81</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. REIDER, M.D.</b>		22e ADDRESS <b>V.A.M.C. FORT HOWARD, MARYLAND 21052</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>2-2-81</b>	23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24 FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md.</b>		ADDRESS <b>1050 York Rd</b>	25a DATE REC'D. BY REGISTRAR <b>FEB 2 1981</b>	25b REGISTRAR'S SIGNATURE <i>R. Reider</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must not be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 81 00376							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Shirley M. DRESSIN				1 28 81				10 A M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JULY 4, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3402 VARGAS CIR., APT. 2B				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND				13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3402 VARGAS CIR., APT. 2B	
14 FATHER'S NAME FIRST MIDDLE LAST Abraham BASS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDA TOBIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 058-07-2610		17 INFORMANT MR. ALAN DRESSIN 3105 MARNAT RD. BALTO., MD 21208					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-15 19 78, to 7-28 19 81, that (I) (we) last saw the deceased alive on 7/28 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/28/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HOWARD J. GARBUR</u>				22e. ADDRESS <u>5310 Old Court Rd.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/30/81		23c. NAME OF CEMETERY OR CREMATORY SHAAREI TELLON		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24 FUNERAL DIRECTOR SOL LEVINSON & ASSOC., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR FEB 4 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT) Dennis J. Driscoll					2a. DATE OF DEATH MONTH DAY YEAR January 6, 1981					2b. HOUR 2:40 p.m.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 1, 1906			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Spring Grove Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2835 Pelham Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Driscoll					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Dorsey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 213-10-0772		17. INFORMANT ADDRESS Winifred D. Kirkner 8122 Loch Raven Blvd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 27</u> , 19 <u>81</u> , to <u>January 6</u> , 19 <u>81</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.												
22b. SIGNATURE <i>Agaton H. Escalante</i>					DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-6-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Agaton H. Escalante, M.D.					22e. ADDRESS SPRING GROVE HOSPITAL CENTER Catonsville, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 10, 1981		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.					ADDRESS 1050 York Road Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JAN 27 1981		25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				81 00378			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALVINA DUNMOYER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 23, 1981</b>		2b. HOUR <b>10:45a</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8/3/49</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQ.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HSWE.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>				13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT SLAWSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VIRGINIA WILLIAMS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 09 9717</b>		17. INFORMANT <b>ROBERT DUNMOYER</b>		ADDRESS <b>ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Complete Cardio-pulmonary Failure</b> <b>5850</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>End Stage Chronic Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 8, 19 81</b> , to <b>January 23, 19 81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 23, 19 81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. Al-Mufti</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-23-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Al-Mufti</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/26/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>J. G. CONNELLY</b>				ADDRESS <b>300 MACE</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 1 0 0 3 7 9							
1. DECEASED NAME (TYPE OR PRINT)		FIRST ADELTA ELsie DUNN				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 CANCER OF LUNG WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 YEAR					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN 26, 1981, to JAN 27, 1981, that (I) (we) last saw the deceased alive on JAN 27, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			



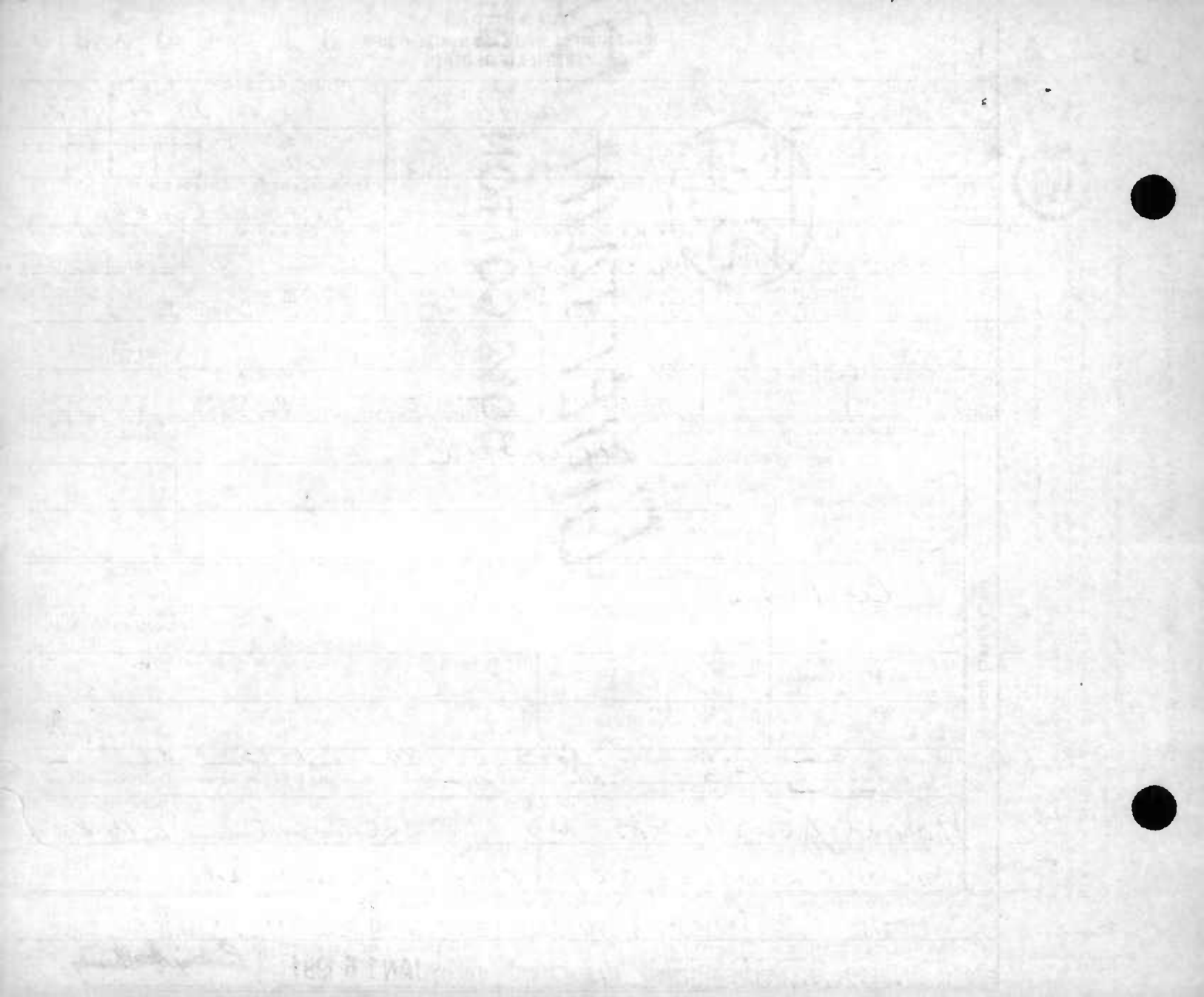
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
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REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>First</i> <i>Eades</i> <i>MIDDLE</i> <i>A-LLEN</i> <i>LAST</i> <i>Eades, Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 13 81</i>		2b. HOUR <i>11 30</i> <i>A</i> <i>M</i>					
3. SEX <i>MALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 26 1919</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WEST VIRGINIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> <i>MD.</i>				
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Valley Nsg. &amp; Conv. Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DISTRICT MGR.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DICTAPHONE CORP.</i>		
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>801 DENNIS AVENUE</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>LESTER A. EADES, SR.</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DOVE HANNAH HYLTON</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>579-09-9430</i>		17. INFORMANT <i>SHIRLEY CROSS</i>		ADDRESS <i>SAME AS 13</i>		DAUGHTER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4860</i> IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Cirrhosis</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>12-5</i> , 19 <i>80</i> , to <i>1-13</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1-13</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Marion C. Kowalewski MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-13-81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARION C. KOWALEWSKI</i>				22e. ADDRESS <i>8604 HARFORD Rd</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>1/15/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ROCKVILLE MONT MD.</i>				
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>				ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MARYLAND</i>		25a. DATE REC'D. BY REGISTRAR <i>20901 JAN 16 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



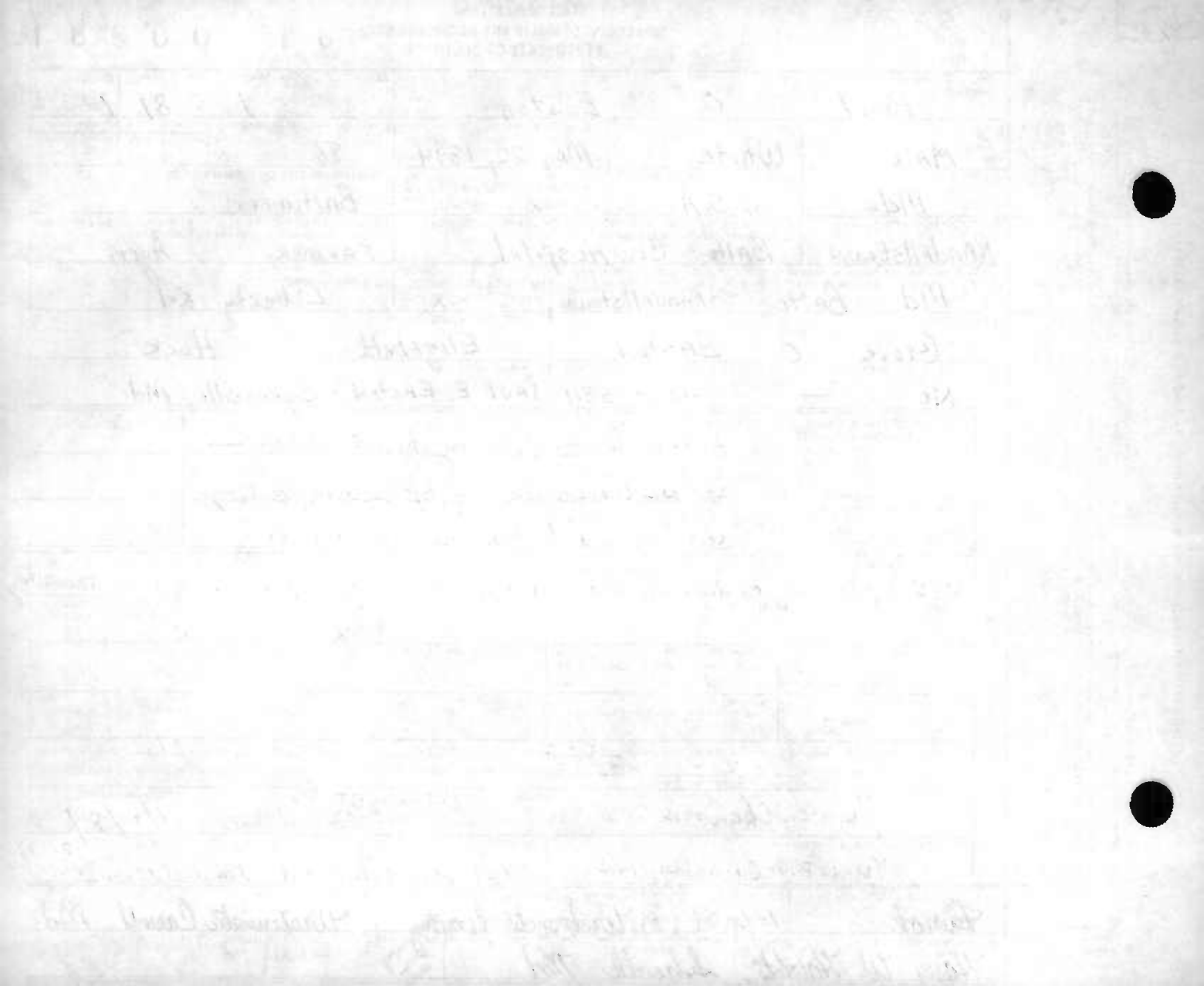
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must not be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 81 00381						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul O. Easton					1 2 81				12:38 P		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 22, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN	
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10 CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Hospital				12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY Agri.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto. Randallstown					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13r. STREET ADDRESS Liberty Rd.				
14 FATHER'S NAME FIRST MIDDLE LAST Grave O. Easton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hook						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 218 14-5311		17. INFORMANT ADDRESS PAUL E. EASTON - Sykesville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). Arteriosclerotic coronary heart disease 4140 DUE TO, OR AS A CONSEQUENCE OF (b). old thrombotic occlusion of left coronary artery DUE TO, OR AS A CONSEQUENCE OF (c). old myocardial infarction, left ventricle APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Severe pulmonary emphysema, severe generalized arteriosclerosis, & aneurysm of right iliac artery											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21r. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-20-1981, to 1-2-1981, that (I) (we) last saw the deceased alive on 1-2-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Yuwen Chang MD		DEGREE Pathologist		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/2/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YU-WEN CHANG, MD.		22r. ADDRESS 5401 Old Court Rd Randallstown Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-6-81		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.					
24. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1981		25b. REGISTRAR'S SIGNATURE					





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 1 0 0 3 8 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ISABELLE BARBARA EBERLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 3 81</b>			2b. HOUR MIN. <b>7:58 A</b>				
3 SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 3, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTO. MEDICAL CTR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21206 6510 Walther Ave. Apt. C7</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph - Senger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antoinette - Louch</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>				
16b. SOCIAL SECURITY NO. <b>212-22-7749</b>			17. INFORMANT ADDRESS <b>Frederick Eberle, husband, same address</b> SS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE ANEMIA</b> <b>5698</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTIPLE INTESTINAL FISTULAE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1/3 81 1/3 81</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>1/3 81</b> to <b>1/3 81</b> , that (I) (we) lost saw the deceased alive on <b>1/3 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>S. Girdhar</i>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/3/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. S. GIRDHAR</b>			22e. ADDRESS <b>GREATER BALTO. MEDICAL CTR. 670L N. CHARLES ST. TOWSON, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/6/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Schimmunek Funeral Home, Inc.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1981</b>			25b. REGISTRAR'S SIGNATURE <i>Robert Schimmunek</i>				



121 BELLE BARBARA ESTATE

BALTIMORE COUNTY

GREATER BALTIMORE CITY

TOWNSHIP

121 BELLE BARBARA ESTATE

MULTIPLE INTERESTS

121 BELLE BARBARA ESTATE

121 BELLE BARBARA ESTATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 3 8 3

REG. NO.

FOR 1. STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN B. EDWARDS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 23 81</b>			2b. HOUR <b>2:10AM</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>5 16 16</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired -</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>A. &amp; P.</b>		
13a. STATE <b>MD.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John P. Edwards</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Richards</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>187-07-6824</b>		
17. INFORMANT ADDRESS <b>Mrs. Virginia Edwards, Same</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>2028</b> IMMEDIATE CAUSE (a) <b>METASTATIC DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LYMPHOMA STAGE IV</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2028</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-14</b> , 19 <b>81</b> , to <b>1-23</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1-23</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Therese</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1-23-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. JEREZ, M.D.</b>			22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/26/81</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md</b>		
24. FUNERAL DIRECTOR NAME <b>ZANNINO Fun. Home - 263 S. Conowingo</b>			ADDRESS <b>263 S. Conowingo</b>			25a. DATE RECD. BY REGISTRAR <b>JAN 26 1981</b>			25b. REGISTRAR'S SIGNATURE <i>Patricia Delaney</i>		

1 23 191 3:10A

EDWARDS

B.

JOHN

64

WHITE

MALE

BALTIMORE COUNTY

GBMC-6701 N. CHARLES ST.

TOWSON

METASTATIC DISEASE

LYMPHOMA STAGE IV

X

81

1-23

81

1-14

81

1-23

1-23-81

X

GBMC-6701 N. CHARLES ST.

A. JERRE, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8100384		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M			
JAMES F ENRIGHT				January 10, 1981					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		NOVEMBER 17, 1904		76 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON D.C.		USA				TOWSON MD BALTO CO MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON MD		ST. JOSEPH HOSPITAL		SALESMAN		AUTOMOBILE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
MD.		BALTIMORE		BALTIMORE				8219 LOCH RAVEN BLVD.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
JAMES ENRIGHT		ELLEN DRISCOLL		NO		217-26-8923		VERA M. ENRIGHT 8219 LOCH RAVEN BLVD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROBABLE CARDIAC ARRHYTHMIA</u> <u>4279</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (s) (this hospital) attended the deceased from <u>Jan 10, 1981</u> to <u>Jan 10, 1981</u> , that (we) last saw the deceased alive on <u>Jan 10, 1981</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (d) (d) view the body after death.									
22b. SIGNATURE OF <u>Maurice B Furlong</u> DEGREE <u>MD</u>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>Maurice B Furlong</u>				MAURICE FURLONG M.D.		7620 YORK RD, TOWSON MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		JAN. 14, 1981		DULANEY VALLEY MEM.		COCKEYSVILLE BALTO MD.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MITCHELL-WIEDEFELD HOME		JAN 16 1981							
6500 YORK RD 21212									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8100385	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES M. ERDMAN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>January 26, 1981</b>			2b. HOUR M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 27, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1101 Newfield Road</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John William Erdman</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret E. Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-07-5488</b>		17. INFORMANT <b>Mrs. Alida Erdman, 1101 Newfield Rd.</b>		ADDRESS <b>21207</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Arrhythmia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>5/22/76</b> to <b>1/26/81</b> , that (I) (we) last saw the deceased alive on <b>1/21/81</b> 19 <b>81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. John C. Heely, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/27/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. John C. Heely, M.D.</b>						22e. ADDRESS <b>1311 Francis Ave., Arbutus, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/29/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Witzke Funeral Home of Catonsville, P.A. 21228</b>						25. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

Handwritten signature: *John H. ...*

POST V. S. MAIL



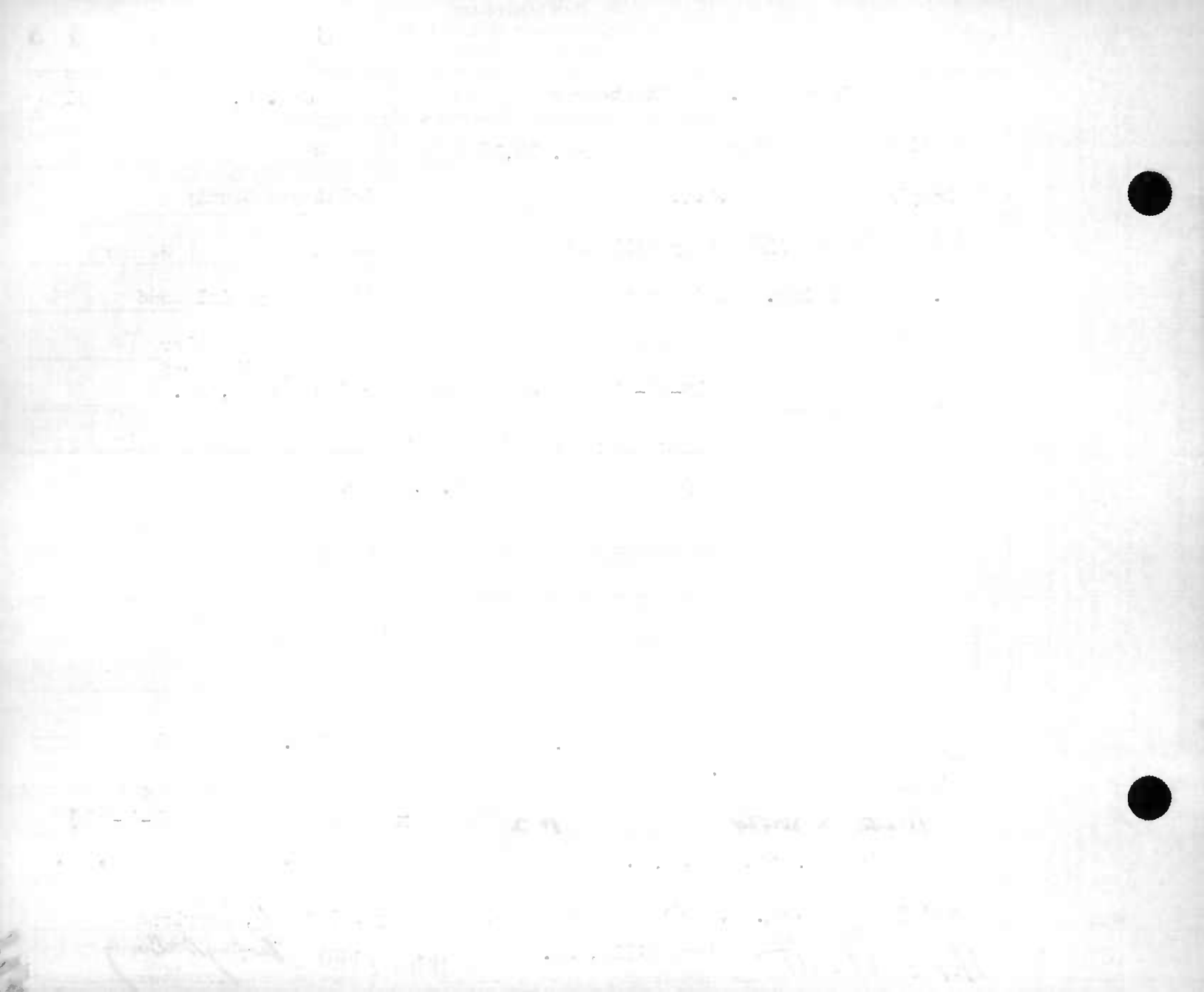
TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 0 3 8 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Barbara C. Etchberger</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 6, 1981</b>		2b. HOUR <b>6:15p<sub>M</sub></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 18, 1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Reisterstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>114 Cherry Hill Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Garment</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Reisterstown</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>114 Cherry Hill Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Schuchart</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Coescentia Zeller</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-03-0748</b>		17. INFORMANT <b>114 Cherry Hill Road</b> <b>Joseph Ryan Reisterstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic C.V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 20</b> , 19 <b>75</b> , to <b>Jan. 6</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Dec. 20</b> , 19 <b>75</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Martin E. Strobel</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-7-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Martin E. Strobel, M.D.</b>				22e. ADDRESS <b>59 Hanover Road, Reisterstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 9, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>W. E. Schuchart</b> Owings Mills, Md.				25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00387	
1. DECEASED NAME (TYPE OR PRINT) <b>John Lester Evans, Jr.</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>1 1 1981</b>		2b. HOUR <b>2100</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>10</b> YEAR <b>1920</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>60</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>1</b> YEAR <b>1981</b>		2d. HOUR <b>2315</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Louisiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2909 Plainfield Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Army</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2909 Plainfield Road</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>L.</b> LAST <b>Evans, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Peters</b> LAST <b>Peters</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1939-1959</b>		17. INFORMANT <b>2909 Plainfield Road</b> <b>Paulette R. Evans Balto. MD. 21222</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic alcoholism with delerium tremens</b> 2910 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Chronic hypertensive cardiovascular disease</b>											
19a. DATE OF OPERATION <b>1/6/1981</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>J. Crossan O'Connor</b>		TITLE (SPECIAL) <b>Deputy</b>		M.D. <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>1/1/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>J. Crossan O'Connor</b>		ADDRESS <b>2112 Dundalk Ave., Balto, Md. 21222</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia K. Brady</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 1 0 0 3 8 8									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Mark		F.		Everhardt				1-21-81		8:35 A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		10-6-50		30 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore, Md.		U.S.A.				Balto. County, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. LOCAL RESIDENCE (TYPE OF HOME OR PLACE OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Dulaney Towson NH						CPA accountant		Self Employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		Balto.		Catonsville		NO		921 Rambling Drive			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Fredrick Everhardt				Elise M. Wolf							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				---		Catonsville, Md. 21228.-Drive Mr. Fredrick Everhardt-921 Rambling					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a): Cardio-Pulmonary Arrest										1/2 hr	
DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic melanoma											
DUE TO, OR AS A CONSEQUENCE OF (c):											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 14, 1981, to Jan 21, 1981, that (I) (we) lost saw the deceased alive on Jan 20, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Charles F. O'Donnell M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/21/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Charles F. O'Donnell M.D.						7501 York Rd Towson Md 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		1/23/81		Loudon Park Cemetery		Baltimore		Maryland			
24. FUNERAL DIRECTOR NAME						24b. DATE REC'D BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
Shelley Dunne Estate Tate Edmundson Jr. @ Catonsville, Md 21228						JAN 26 1981		[Signature]			

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1990

11/10/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

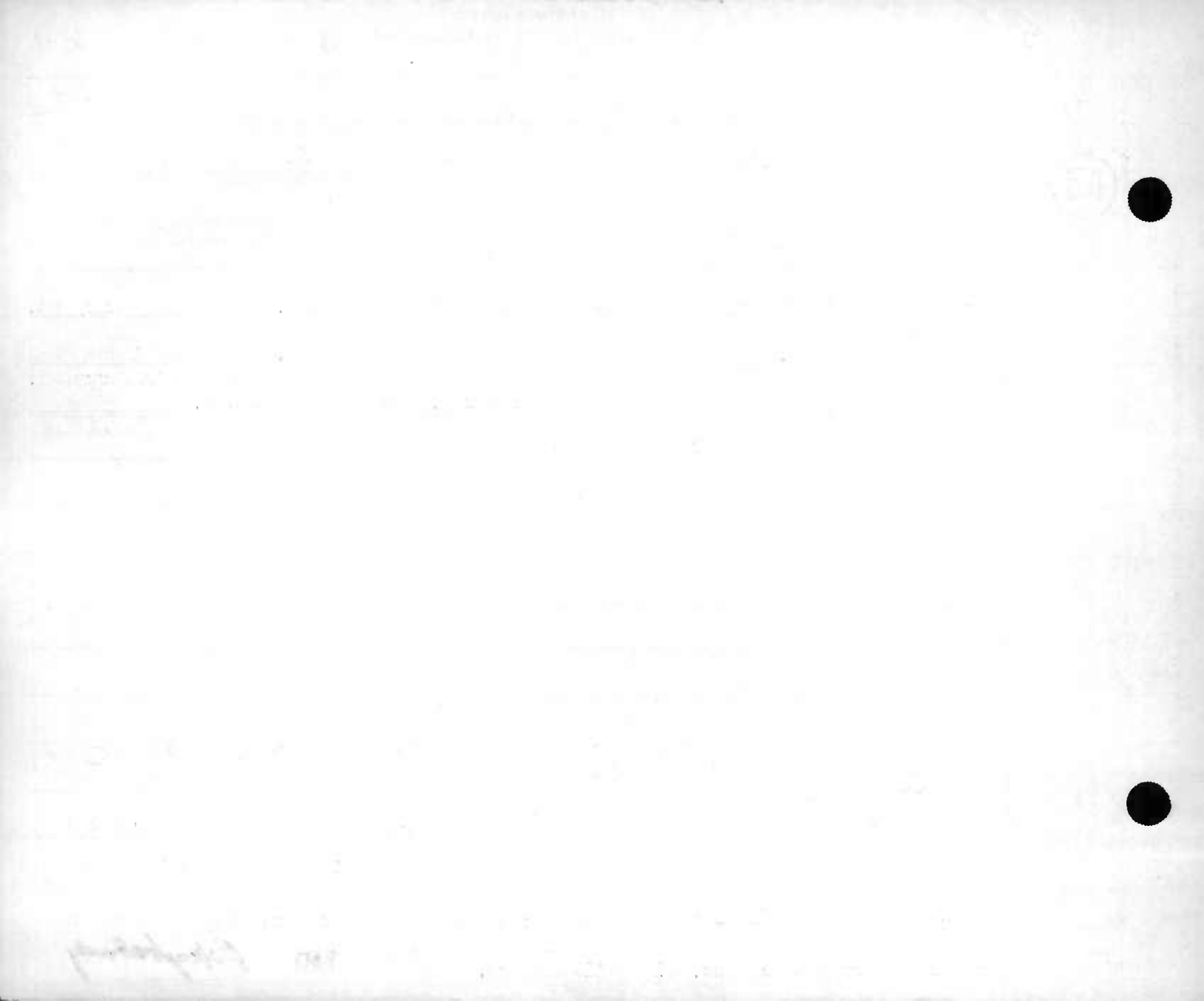
8 1 0 0 3 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Sara Margaret Ferguson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-4-81</b>		2b. HOUR <b>7<sup>15</sup></b> P. M.						
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8-5-1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10 CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Forest Haven Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House wife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lansdowne</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2201 Apt. B Hammonds Ferry Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas E. Ireland</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alma A. Robinson</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>214-01-1831</b>			17 INFORMANT <b>Lester L. Ferguson</b>			ADDRESS <b>2201 Apt. B</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-6</b> , 19 <b>78</b> , to <b>1-4</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>12-30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.											
22b. SIGNATURE <b>Harold B. Bob</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-6-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold B. Bob</b>						22e. ADDRESS <b>7220 Park Heights 21208</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>01-08-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>						ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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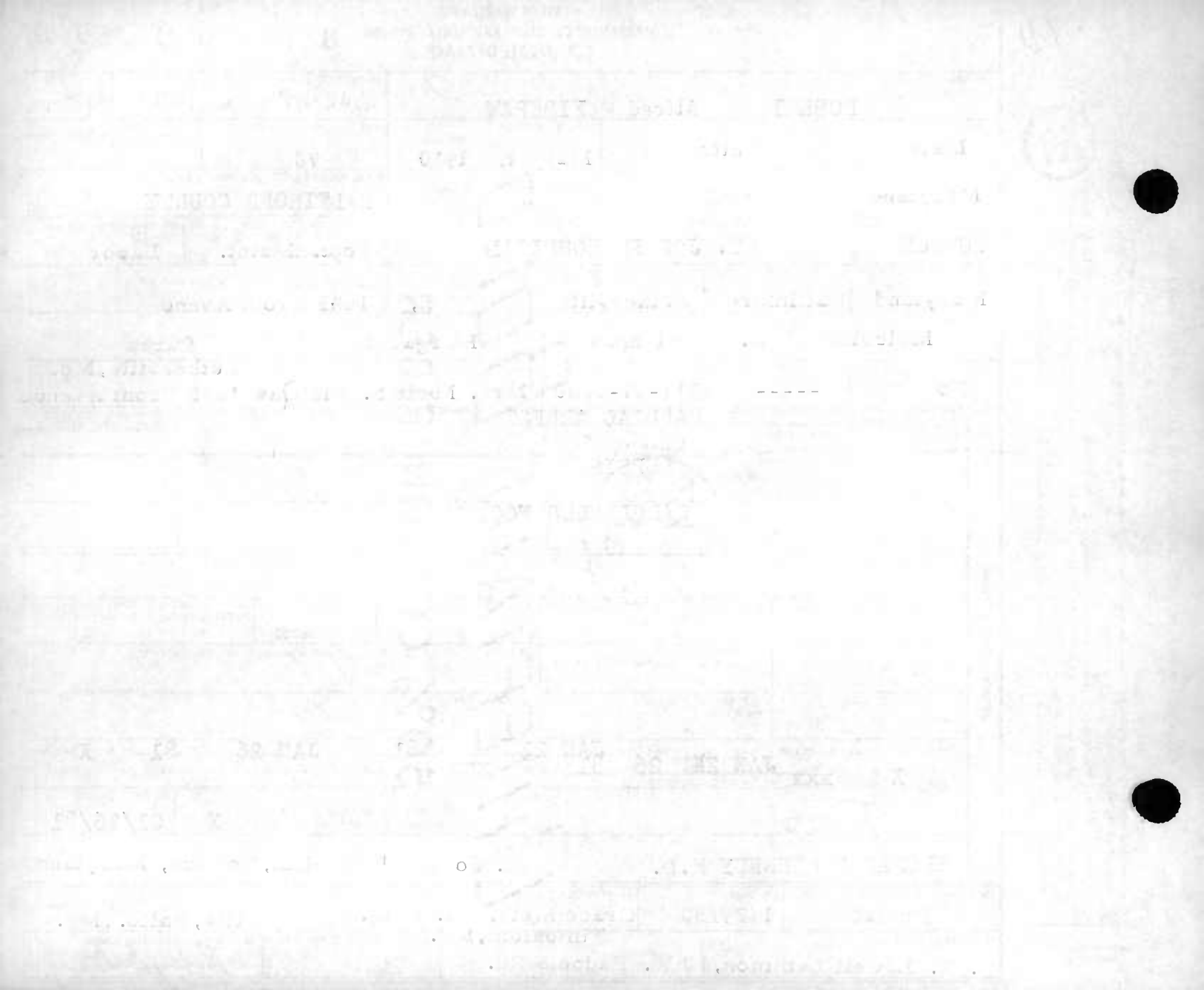
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8100390						
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT Alfred FISHPAW</b>							2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 26, 1981</b>			2b. HOUR <b>9<sup>15</sup> P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 1, 1910</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.									
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supt. / Maint.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1425 Front Avenue</b>								
14. FATHER'S NAME <b>Malcolm A. Fishpaw</b>					15. MOTHER'S MAIDEN NAME <b>Margaret Parks</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-07-5680</b>		17. INFORMANT ADDRESS <b>Mrs. Josie S. Fishpaw 1425 Front Avenue Lutherville, Md.</b>												
18. CAUSE OF DEATH (Enter only one cause per line. Do not record (c) if death was caused by (a) or (b).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b> Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>GANGRENOUS FOOT</b> <b>Gangrenous Foot</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (X) (this hospital) attended the deceased from <b>JAN 23</b> , 19 <b>81</b> , to <b>JAN 26</b> , 19 <b>81</b> , that <b>X</b> (we) lost <b>saw the deceased alive on above</b> <b>JAN 26</b> , 19 <b>81</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>(we)</b> (did) <b>not</b> view the body after death.																
22b. SIGNATURE <b>[Signature]</b>					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>01/26/81</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS P. KENNEDY M.D.</b>					22e. ADDRESS <b>St. Josephs' Hospital, Towson, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/29/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace Meth. Ch. Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Balto., Md.</b>								
24. FUNERAL DIRECTOR NAME <b>J. E. Lowell Lemmon, 10 W. Padonia Rd.</b>					ADDRESS <b>Timonium, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 00391									
1. FOR STATE REGISTRAR					1. DECEASED NAME					2a. DATE OF DEATH				2b. HOUR					
					Mary Emma Fitch					01 31 81				7P. M.					
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE				
Female					White					01 03 1889					92 YRS.				
7a. BIRTHPLACE					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED					9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland					USA					NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					Baltimore County MD.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION					12a. USUAL OCCUPATION					12b. KIND OF BUSINESS OR INDUSTRY				
Fullerton					7601 Fitch Lane					Housewife					Homemaking				
13a. STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS?					13d. STREET ADDRESS				
Maryland					Baltimore					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					7601 Fitch Lane 21236				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
William					McLean					Debora					Cropsy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS				
No					214-54-5326					Louis Fitch					7609 Fitch Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Congestive heart failure.										10 yrs.									
DUE TO, OR AS A CONSEQUENCE OF																			
(b) ASCVD and Diabetes Mellitus										10 yrs.									
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1967, 19 to Feb. 1, 1981, that (I) (we) last saw the deceased alive on Jan. 29, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																			
22b. SIGNATURE					DEGREE					22c. DATE SIGNED									
Theodore E. Evans					MD					2/2/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS														
Theodore E. Evans, M.D.					9660 Belair Rd., Balto. Md. 21236														
23a. BURIAL, CREMATION, REMOVAL					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
Burial					2/3/81					St. Joseph's Ceme					Fullerton Baltimore Md.				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
Lassahn Funeral Home					7401 Belair Road					FEB 5 1981									



RECEIVED  
MAY 10 1964

WATER  
FALLS  
MAY 10 1964

THE  
STATE OF  
NEW YORK  
IN SENATE  
JANUARY 13, 1964  
REPORT  
OF THE  
COMMISSIONER OF  
THE DEPARTMENT OF  
SOCIAL SERVICES  
ON THE  
ADMINISTRATIVE  
AND FINANCIAL  
OPERATIONS OF THE  
DEPARTMENT OF  
SOCIAL SERVICES  
FOR THE FISCAL YEAR  
ENDING DECEMBER 31, 1963  
BY  
THE COMMISSIONER  
OF THE DEPARTMENT  
OF SOCIAL SERVICES  
ALBANY, NEW YORK  
1964

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 81 00392			
1. DECEASED NAME (TYPE OR PRINT) <b>George T. Fitzer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11/14/81</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7/2/37</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>County</b>	
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Villa N.C.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Motor inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>BALTO.</b>				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George T. Fitzer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Klees Mary Elizabeth</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Army</b>		17. INFORMANT <b>Mrs. Mildred V. Turner</b>		17. ADDRESS <b>417 Nottingham Rd. Balto. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1539 Carcinoma, colon</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/15/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>G. Truman Schwab</b>		ADDRESS <b>5151 Balto. Nat'l. Pike</b>		25. DATE OF REGISTRATION <b>JAN 20 1981</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

2010 RELEASE UNDER E.O. 14176

Index

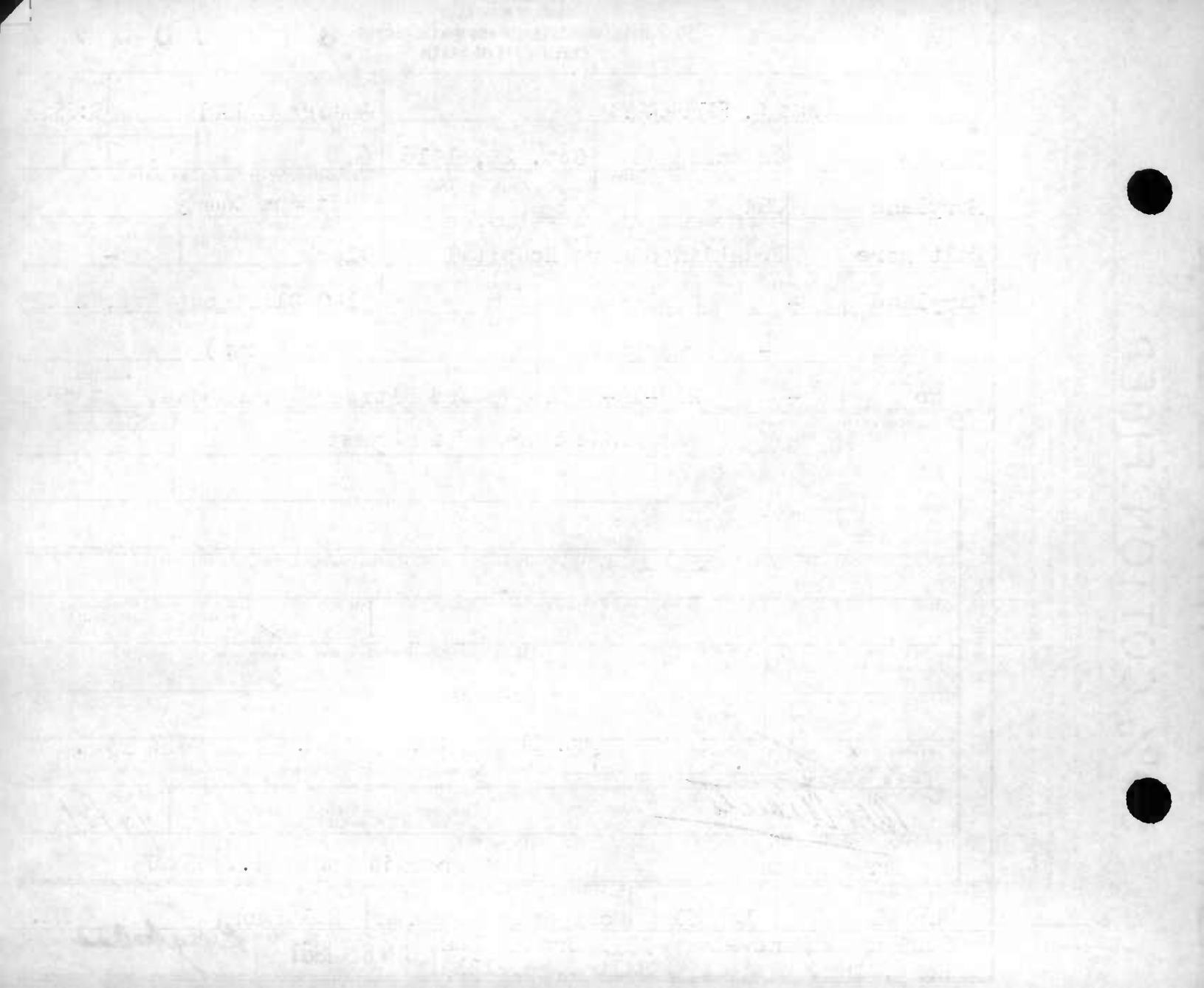


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FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 1 0 0 3 9 3	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Agnes G. FITZGERALD				MONTH DAY YEAR January 4, 1981		2b. HOUR 9:55p M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3140 Clifftmont Ave. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST James - Kruszynski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-10-3492		17. INFORMANT ADDRESS Howard Fitzgerald, husband, same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic cancer of the breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that <input checked="" type="checkbox"/> (this hospital attended the deceased from Jan. 4 1981, saw the deceased alive on Jan. 4 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <i>Dr. DelMonte</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/4/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. DelMonte				22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/7/81		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		24b. ADDRESS 3331 Brehms Lane Balto., Md. 21213		25a. DATE REC'D. BY REGISTRAR JAN 6 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 0 3 9 4	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Baby Girl Fleig						Jan. 30, 1981			6:55a <sub>M</sub>		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
Female		White		Jan. 30, 1981				3		53	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		St. Joseph Hospital						N/A		N/A	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3811 Forrester Ave. 21206		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
John - Hall			Joy I. Fleig								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NA			NA		St. Joseph Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Prematurity											
7530 DUE TO, OR AS A CONSEQUENCE OF (b) Congenital renal dysgenesis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
NA						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19			NA					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
			NA								
22a. I certify that (he/she) attended the deceased from Jan. 30, 19 81, to Jan. 30, 19 81, that (he/she) saw the deceased alive on Jan. 30, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he/she) (did) (not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Henry S. Crist, M.D.									Feb. 5, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Henry S. Crist, M.D.			7620 York Rd. Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Referred to hosp.			Feb. 5, 1981		Parkwood			Baltimore County, Md.			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
			FEB 9 1981			[Signature]					



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100395

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FANNIE FLOMENBAUM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-1-81</b>			2b. HOUR MIN. <b>10:25 AM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 9, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>					13b. CITY OR TOWN <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MEYER</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-74-7666</b>		17. INFORMANT ADDRESS <b>JACK FLOMENBAUM</b> <b>8 QUIMPER CT., APT. 1B #21208</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia.</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-27-</b> 19 <b>80</b> , to <b>1-1-</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1-1-</b> 19 <b>81</b> , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Soonchal Hong</b>			DEGREE			22c. DATE SIGNED <b>1-1-81</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOONCHUL HONG</b>			22e. ADDRESS <b>Baltimore County General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI ZION</b>		23d. LOCATION CITY OR TOWN COUNTY <b>ROSEDALE BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1981</b>			25b. REGISTRAR'S SIGNATURE <b>Ruby Belmont</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATS. & CLERK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

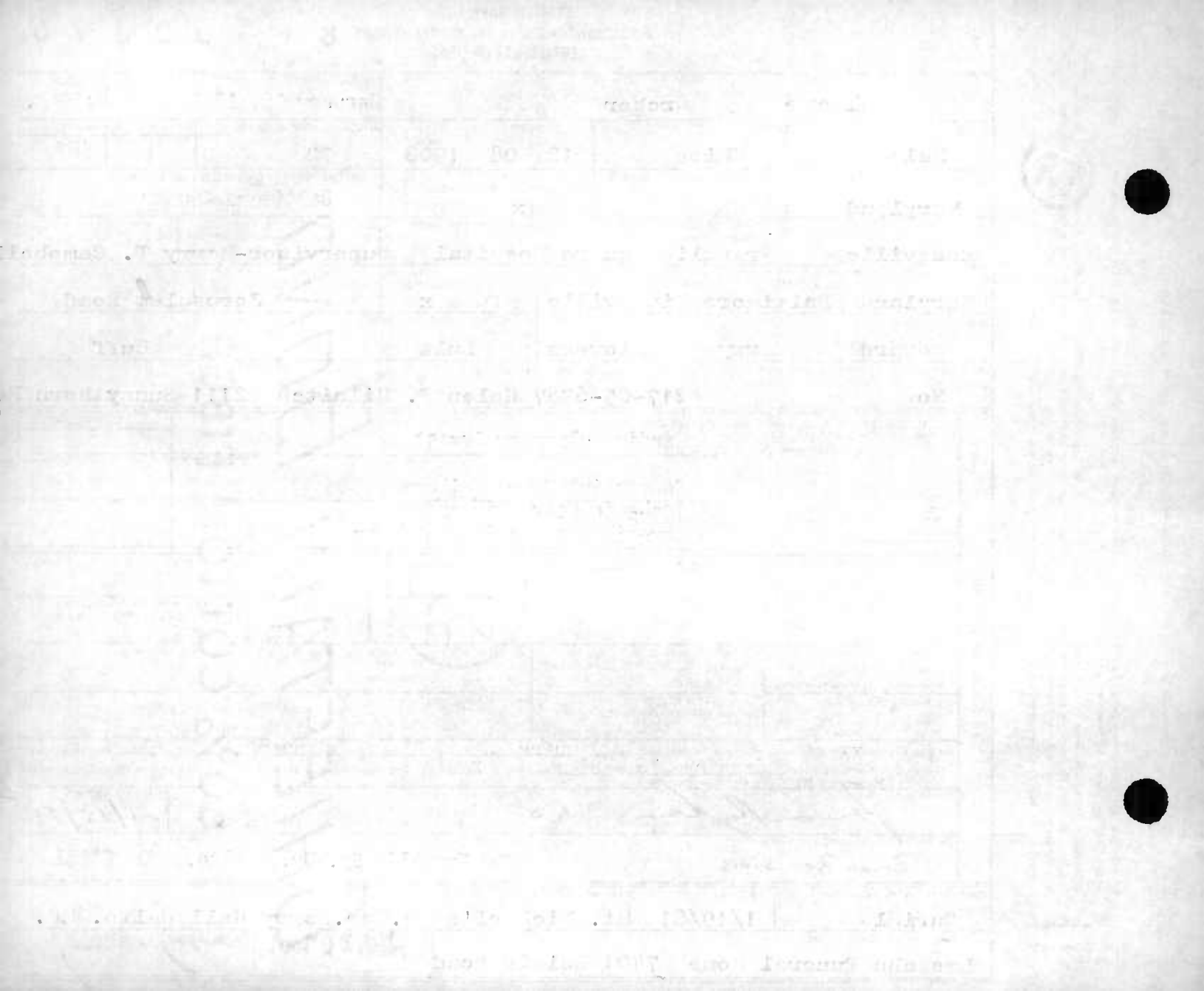
BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8100396			
FOR 1 - STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) James Archer FLOWERS						2a. DATE OF DEATH MONTH DAY YEAR January 15, 1981				2b. HOUR 6:10 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 08 1908		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-Harry T. Campbell			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Kingsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Jerusalem Road			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Harry Flowers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Duff									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-6287		17. INFORMANT Helen F. Hilditch				ADDRESS 2111 Sunnyside Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure (c) Ischemic Heart Disease Chronic Obstructive Pulmonary Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from January 6, 1981, to January 15, 1981, that (X) (we) last saw the deceased alive on January 15, 1981, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, ( ) (we) did not view the body after death.)													
22b. SIGNATURE Brian Ron Sims						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian Ron Sims						22e. ADDRESS 9000 Franklin Sq. Dr., Balto., MD 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/19/81		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Perry Hall Balto. Md.							
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home						ADDRESS 7401 Belair Road		25a. DATE RECEIVED BY REGISTRAR JAN 20 1981		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8100397

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth F. Forrester</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 30 81</b>		2b. HOUR <b>330 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>05 13 93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Rossville</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>13b</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Conrad Dickhaut</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Louise Fleishman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 10 0842</b>		17. INFORMANT ADDRESS <b>Marshall A. Forrester, Jr. Balto., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Severe Senile Dementia &amp; perkinson's disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Severe degree Dementia, Perkinson's disease</b>					
19a. DATE OF OPERATION <b>2 9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>6/25/1979</b> to <b>1/30/1981</b> , that <b>he</b> (we) last saw the deceased alive on <b>3 pm 1/30/1981</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/30/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHIN - M. TUN</b>		22e. ADDRESS <b>2110 pot spring Road Md 21093</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. County, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

1505 York Road, Baltimore, Md. 21212  
 Henry W. Jenkins & Sons Co.  
 Parkwood Cemetery, Baltimore County, Md.

No 212 10 0342 Marshall A. Forrester, Jr. n. l. o., m. l.  
 Conrad Dickson Lillian Louise  
 Maryland Baltimore x 2343 Loch Haven Blvd.  
 Rossville  
 Maryland x 2343 Loch Haven Blvd.  
 Baltimore County  
 27

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100398

REG. NO.

FOR 1. STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) Lena Rachel Christine France			MONTH DAY YEAR January 4, 1981			M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MINS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2801 Glendale Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST) John W. Davis			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Elizabeth Butzner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 076-20-3560			17. INFORMANT ADDRESS Balt., Md. 21214 Bernard L. Wamhoff 5007 Plymouth Rd.		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) 4100 IMMEDIATE CAUSE (a) Acute myocardial ischemia + infarct DUE TO, OR AS A CONSEQUENCE OF, (b) Coronary artery insufficiency DUE TO, OR AS A CONSEQUENCE OF, (c) Atherosclerotic Cardio Vasc. Dis. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48720000								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from Aug 19 76 to Dec 18 80 that (I) (we) last saw the deceased alive on Dec 18 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Type and sign name of physician or medical examiner who viewed the body after death.)								
22a. SIGNATURE Dr. Frank T. Kasik Jr.			DEGREE			22b. DATE SIGNED 1/5/81		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Frank T. Kasik Jr. M.D.			22e. ADDRESS 9005 Harford Road Balt., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan 7 1981		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland			25a. DATE REC'D. BY REGISTRAR JAN 7 1981			25b. REGISTRAR'S SIGNATURE R. J. McCreedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## References



1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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growth stage: 100%

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Figure 1

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1. General  
 2. Particular  
 3. Conclusion

X

John A. Smith

X

12/21

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1994年12月

**Abstracts included:**

12-1-1962

1. 1. 1. 1. 1.

1941-1942, 1943-1944, 1945-1946, 1947-1948, 1949-1950, 1951-1952, 1953-1954, 1955-1956, 1957-1958, 1959-1960, 1961-1962, 1963-1964, 1965-1966, 1967-1968, 1969-1970, 1971-1972, 1973-1974, 1975-1976, 1977-1978, 1979-1980, 1981-1982, 1983-1984, 1985-1986, 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 26

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00399

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 4 19 81 |  | 2b. HOUR<br>1 4 19 81   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elwood Joseph Frisch, Jr   |  | 3. SEX<br>male   |  | 4. RACE<br>white  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 20 28  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>52 YRS.                          |  | 7c. DATE<br>PRONOUNCED<br>DEAD<br>MONTH DAY YEAR<br>1 4 19 81   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>automobile/8102 Pulaski Highway               |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Fireman   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>-                              |  | 13a. STATE<br>Maryland  |  |
| 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br>4318 Brehms Lane.21206   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elwood J. Frisch, Sr.        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elda - Valentine   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>Korean 220-12-4475                         |  | 17. INFORMANT<br>ADDRESS<br>Antoinette Frisch, wife, same address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>(b) _____<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                        |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |
| ACTUAL<br>SIGNATURE<br>Hormez R. Guard, M.D.  |  | TITLE (SPECIFY)<br>Assistant   |  | DATE<br>SIGNED 1/4/81   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  | ADDRESS<br>111 Penn Street, Balto., MD 21201                           |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/7/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park  |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore  |  | COUNTY<br>BALTIMORE  |  | STATE<br>Md.  |  |
| 24. FUNERAL DIRECTOR<br>Schimmunek Funeral Home, Inc.   |  | ADDRESS<br>3331 Brehms Lane<br>Balto., Md. 21213                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1981   |  |

REGISTRAR'S SIGNATURE  
[Signature]

• • • • •



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100400

REG. NO.

|   |  |   |  |   |        |  |  |   |                             |  |  |
|---|--|---|--|---|--------|--|--|---|-----------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Lillian  | MIDDLE | LAST<br>Fromkin  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-16-81 |   | 2b. HOUR<br>6 <sup>PM</sup> |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2-9-98  |        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                             | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW JERSEY   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |   |                             |  |  |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NEW JEWISH CONVALESCENT CENTER |  |   |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |                             |  |  |
| 13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             | 13e. STREET ADDRESS<br>3914 LABYRINTH RD. #21215   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JACOB COHEN   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>TILLIE UNKNOWN  |        |  |  |   |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>146-26-2455   |        | 17. INFORMANT<br>MRS. GERALDINE SHANE<br>6606 PARK HEIGHTS AVE., APT. 502 #21215   |  |   |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Heart Failure.</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Decubitis Ulcers</u> |  |   |  |   |        |  |  |   |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Organic Brain Syndrome</u>  |  |   |  |   |        |  |  |   |                             |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> 19 <u>75</u> , to <u>1/16</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |   |        |  |  |   |                             |  |  |
| 22b. SIGNATURE<br><u>R. K. K...</u>   |  |   |  |   |        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/16/81   |                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |        | 22e. ADDRESS   |  |   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>REMOVAL/BURIAL   |  |   |  | 23b. DATE<br>1-18-81  |        | 23c. NAME OF CEMETERY OR CREMATORY<br>BROTHERS OF ISRAEL CEM.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>TRENTON N.J.                                      |                             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215  |  |   |  |   |        | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>R. K. K...</u>   |                             |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DMMH-17  
(VR A15 ME (5))  
15M 2/80

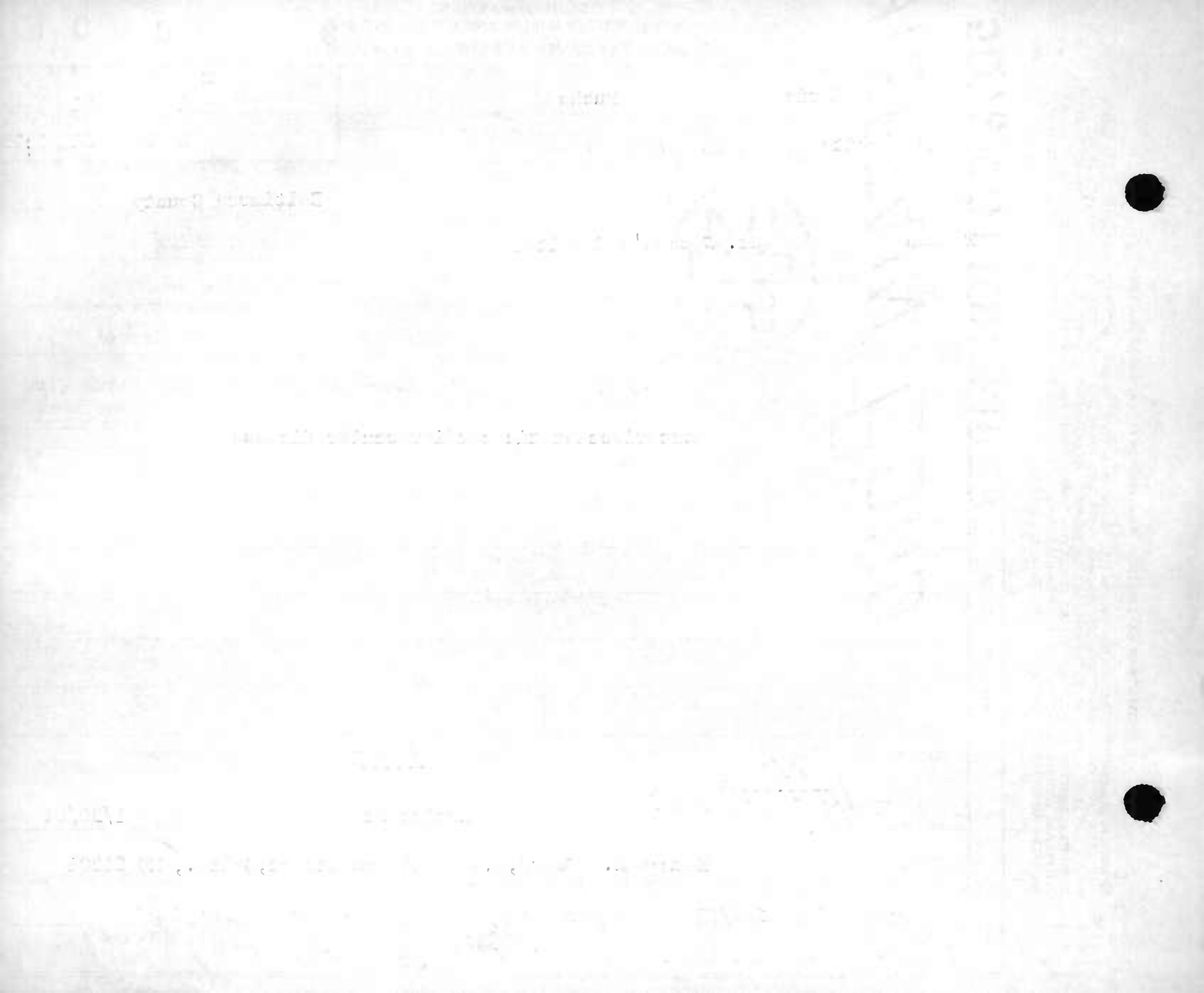
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |                         |  |  |   |  |   |  |   |  |
|---|-------------------------|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marie Fuchs</b>   |                         |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 30 19 81</b>  |  |   |  | 2b. HOUR<br>M<br><b>9:23</b>  |  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 13, 1893</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>87</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 30 19 81</b>                                 |  | 2d. HOUR<br>M<br><b>9:23</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Clothier</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |  |  |   |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3110 Reuckert Ave</b>                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christian Fuchs</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Siegel</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-9920</b>       |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Marie Miss <del>Marie</del> Schmidt 8421 Loch Raven Blvd</b> |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |                         |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |                         |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>H. R. Guard</b>  |                         |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | DATE SIGNED<br><b>1/30/81</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>  |                         |  |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2/2/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc.</b>  |                         |  |  | ADDRESS<br><b>Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1981</b>  |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |  |   |  | REG. NO.                                     |  |
|--|--|--|---|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MICHAEL - FURST   |  |  | 2r. DATE OF DEATH<br>MONTH DAY YEAR<br>1 1 81 |   |  | 2b. HOUR<br>12 <sup>25</sup> P M   |  |   |  |  |  |
| 3 SEX<br>MALE.   |  | 4 RACE<br>WHITE<br>XXXXXXXXXX  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>05 04 10   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8 IF UNDER 24 HRS<br>HOURS MIN.              |  |
| 9 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  |  | 10 CITIZEN OF WHAT COUNTRY?<br>USA   |   | 11 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 12 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY .MD.                        |  |   |  |  |  |
| 13 CITY OR TOWN OF DEATH<br>RANDALLSTOWN   |  | 14 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GENERAL HOSP. |   |   |  | 15 USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MERCHANT           |  | 16 KIND OF BUSINESS OR INDUSTRY<br>RETAIL   |  |  |  |
| 17 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE MARYLAND 17b. COUNTY BALTO. 17c. CITY OR TOWN BALTIMORE   |  |  |   | 18 INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 19 STREET ADDRESS<br>7901 TIVERTON RD. #21133  |  |   |  |  |  |
| 20 FATHER'S NAME<br>FIRST MIDDLE LAST<br>ABRAHAM FURST   |  |  |   | 21 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FRUMA UNKNOWN   |  |  |  |   |  |  |  |
| 22 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 23 SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>213-30-2392  |   | 24 INFORMANT MR. GILBERT FURST<br>ADDRESS 3304 NERAK RD. BALTO., MD 21208   |  |  |  |   |  |  |  |
| 25 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) -   |  |  |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |  |   |  |  |  |
| 26a. DATE OF OPERATION<br>-  |  | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-  |   |   |  | 27a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 27b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 28b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>-   |  |  |  |   |  |  |  |
| 29a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 29b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 29c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>- - - - -  |  |  |  |   |  |  |  |
| 29d. I certify that (I) (this hospital) attended the deceased from 1-1-1981 to 1-1-1981, that (I) (we) last saw the deceased alive on 1-1-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |   |   |  |  |  |   |  |  |  |
| 30 SIGNATURE<br>[Signature]<br>DEGREE  |  |  |   | 31 ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  |  | 32 DATE SIGNED<br>1-1-81  |  |  |  |
| 33 PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. S. D. PATEL   |  |  |   | 34 ADDRESS<br>Bal. County Gen. Hospital   |  |  |  |   |  |  |  |
| 35 BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 36 DATE<br>JAN. 2, 1981  |   | 37 NAME OF CEMETERY OR CREMATORY<br>CHEVRA AHAVAS CHESED  |  | 38 LOCATION<br>CITY OR TOWN COUNTY STATE<br>RANDALLSTOWN BALTO. MD                   |  |   |  |  |  |
| 39 FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.   |  |  |   | 40 ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  | 41 DATE REC'D. BY REGISTRAR<br>JAN 7 1981  |  | 42 REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |  |  |   |  |
|--|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Carroll Garrish, Sr.</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 25, 1981</b>             |   |   | 2b. HOUR<br><b>9 a.m.</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 3, 1931</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Baltimore County Gen. Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Construction Worker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  | 13b. CITY OR TOWN<br><b>Balto.</b>                                   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1 Shropshire Court</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leonard L. Garrish</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary M. Leaf</b> |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-28-6449</b>                    |  | 17. INFORMANT<br><b>Shirley B. Garrish</b>  |   | 17. ADDRESS<br><b>71 Pennington Circle<br/>Owings Mills, Md. 21117</b>                         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>429.2</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>acute</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>chronic alcoholism</b>   |  |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Stanley Steinbach</b>   |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |   |  | 22c. DATE SIGNED<br><b>JAN. 26, 1981</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stanley Steinbach</b>  |  |  |  | 22e. ADDRESS<br><b>11 SLADE Ave, Pikesville, Md</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 28, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Carroll, Md.</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H. E. Ehrhardt</b>  |  |  |  | ADDRESS<br><b>Owings Mills, Md.</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1981</b>   |  | REGISTRAR'S SIGNATURE<br><b>Robert H. H. H.</b>               |  |



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• *For a full list of titles*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 0 4 0 4   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LILLIAN G. GATELY</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 31 81</b>  |  | 2b. HOUR<br><b>10:31 A</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 13 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTO. MEDICAL CTR.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. - Sales</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Rerson</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Herman Link</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Augusta Kuhlman</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-28-1604a</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. A. Joyce Dignazio 5611 Mayview Ave.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5570</b> IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MESENTERIC THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>1/26 81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>1/31 81</b>   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/26 81</b> to <b>1/31 81</b> , that (I) (we) lost saw the deceased alive on <b>1/31 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>DR. L. POLLACHI</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/31/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. L. POLLACHI</b>  |  |   |  | 22e. ADDRESS<br><b>6701 GREATER BALTO. MEDICAL CTR. N. CHARLES ST. TOWSON, MD.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 3, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J. Ruck, Inc.</b>  |  |   |  | ADDRESS<br><b>Baltimore, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1981</b>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>R. J. McBrady</i>  |  |  |  |

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LILLIAN

DAKOTA COUNTY

REGISTERED NURSE, MEDICAL ST.

10200

DATE OF BIRTH TO Y. 1922

REGISTERED NURSE

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X

REGISTERED NURSE, MEDICAL ST.  
1921

DR. L. POLLOCK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 8100405   |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|----------|--|--|---|--|--|--|--|---------------------------------|--|--|--|--|-----------------------------|--|-----------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |  |  |  | 2b. HOUR |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 3. SEX   |  |  |  |  | 4. RACE  |  |          |  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN. |  |  |
| RUTH GEES  |  |  |  |  | Female   |  |  |  |  | White  |  |          |  |  | May 26, 1894  |  |  |  |  | 86 YRS.                         |  |  |  |  |                             |  |                             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |          |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| Maryland   |  |  |  |  | USA  |  |  |  |  |  |  |          |  |  | Baltimore County MD.  |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| Owings Mills   |  |  |  |  | Baptist Home   |  |  |  |  | Clerk  |  |          |  |  | Balto. City   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 13a. STATE   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |          |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |  | 13e. STREET ADDRESS             |  |  |  |  |                             |  |                             |  |  |
| Maryland   |  |  |  |  | BALTO  |  |  |  |  | Baltimore  |  |          |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 512 Castle Drive                |  |  |  |  |                             |  |                             |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| Richard Gees   |  |  |  |  | Emma Charlotte Mansfield   |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT ADDRESS  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| No   |  |  |  |  | 214 40 5889  |  |  |  |  | Mr. Edward Brandt, Towson, Md.   |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1953 Renal Failure  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pelvic carcinoma  |  |  |  |  |  |  |  |  |  | Weeks  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  | Years  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Vaginal bleeding   |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |          |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 12, 1980, to Jan 22, 1981, that (I) (we) lost saw the deceased alive on Jan 22, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  | 22b. SIGNATURE Rolando Viegas MD   |  |  |  |  | 22c. DATE SIGNED 1/22/81   |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| Rolando Viegas   |  |  |  |  | 115 Chestnut Hill Rd, Beltsville, Md   |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |          |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| Burial   |  |  |  |  | 1/24/81  |  |  |  |  | Baltimore  |  |          |  |  | Baltimore Maryland  |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  | 24b. ADDRESS   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |          |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |
| Henry W. Jenkins & Sons Co.  |  |  |  |  | 4905 York Road Balto., Md. 21212   |  |  |  |  | JAN 23 1981  |  |          |  |  | [Signature]   |  |  |  |  |                                 |  |  |  |  |                             |  |                             |  |  |



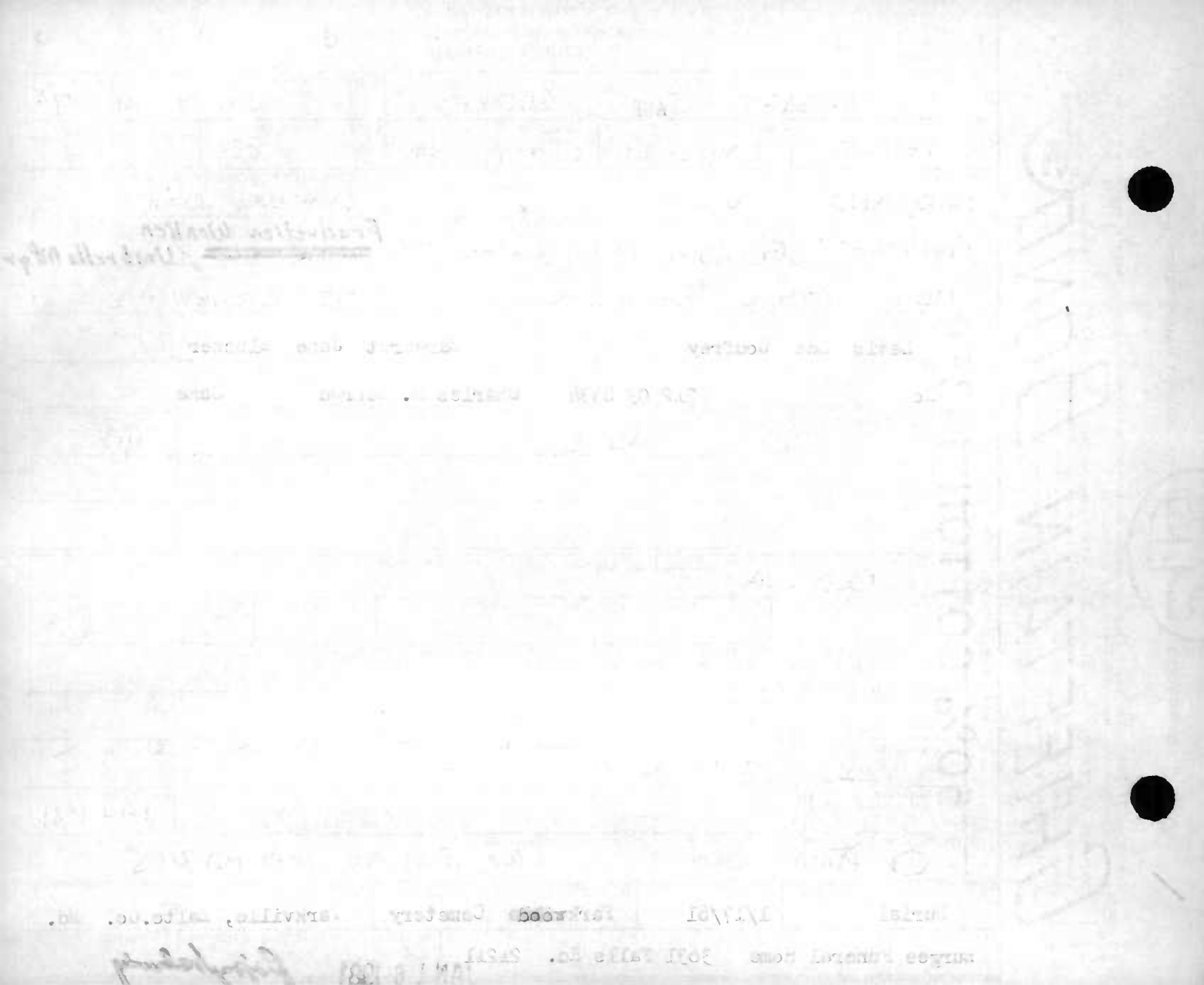
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at or

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8100406  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARGARET JANE GEORGE  |  |   |  | MONTH DAY YEAR<br>JAN 14 1981   |  | 2b. HOUR<br>7A <sub>M</sub>  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT 13 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GARRISON VALLEY CENTER, INC |  | 12. USUAL OCCUPATION (IF DECEASED WAS WORKING)<br>Production Worker   |  | 13. INDUSTRY<br>Umbrella Mfg   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. CITY OR TOWN WESTMINSTER   |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>2921 BIRDVIEW AVE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Lewis Lee Godfrey  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Jane Blucher   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212 09 8334   |  | 17. INFORMANT<br>Charles D. George  |  | 17. ADDRESS<br>Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>OLD CIA   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAR 11, 1980, to JAN 14, 1981, that (I) (we) last saw the deceased alive on JANUARY 13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we do not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Dr. David Lebow   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1-14-1981  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS<br>3640 FORDS LANE BALTO MD 21215  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/17/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Balto. Co. Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME Burgee Funeral Home  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br>JAN 16 1981  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8100407  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIUS K. GERLACH  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 01 29 81  |  | 2b. HOUR 8:17 PM  |  |
| 3 SEX MALE  |  | 4 RACE WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR 05 01 01   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD  |  |
| 10. CITY OR TOWN OF DEATH CATONSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOL MAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE MARYLAND   |  | 13b. COUNTY BALTIMORE  |  | 13c. CITY OR TOWN CATONSVILLE  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN   |  | 13e. STREET ADDRESS 1321 RIDGE ROAD, 21228   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO 216-09-0119  |  | 17. INFORMANT ADDRESS JULIUS W. LICHTER 305 W. CHESAPEAKE AVE.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Massive myocardial infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Parkinsonism, cerebral ischemia  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 June 1975, to 29 Jan 1981, that (I) (we) last saw the deceased alive on 29 Jan 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE James E. Rowe  |  |  |  | DEGREE M.D.  |  | 22c. DATE SIGNED 1/29/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. E. ROWE  |  |  |  | 22e. ADDRESS Summit Nursing Home   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 01-31-81   |  | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND   |  |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.  |  | ADDRESS 4107 WILKENS AVE.  |  | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981   |  | 25b. REGISTRAR'S SIGNATURE  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                     |  |   |
|--|--|--|--|---|--|--|---------------------|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |                     |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN FREDERICK GIESER   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 10, 1981 |  | 2b. HOUR<br>6 A. M. |  |   |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>December 3, 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |                     | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Co. Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                            |                     |  |   |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>old Court Nursing Home |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Carpenter   |                     | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Carroll Finksburg   |  |  |  |   |  |  |                     |  |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1709 Hoff Lane  |  |   |  |  |                     |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George H. Gieser  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Voltz   |  |  |                     |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>217-01-3290  |  | 17. INFORMANT ADDRESS<br>Mrs. Anna M. Barrick Finksburg, Md.  |  |  |                     |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>COPD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <u>years</u> |  |  |  |   |  |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>HRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>CVA, with rt. hemiplegia. (old)</u>  |  |  |  |   |  |  |                     |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                     |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                     |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 80</u> , to <u>Jan. 10, 1981</u> , that (I) (we) last saw the deceased alive on <u>Jan. 9, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |  |                     |  |   |
| 22b. SIGNATURE<br><u>P. Matus, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |                     | 22c. DATE SIGNED<br>1/12/81  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BIENVENIDO R. MATOS, M.D.   |  |  |  | 22e. ADDRESS<br>21 CRANBROOK RD. COCKEYSVILLE, MD-21036   |  |  |                     |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 13, 81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Memorial  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Finksburg, Md.                         |                     |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Eline Funeral Home Reisterstown, Md. 21136   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McCreedy</u>                               |                     |  |   |

BP



| NAME              |  | RESIDENCE                                 |  | DATE               |  |
|-------------------|--|---|--|--------------------|--|
| John A. Smith     |  | 123 Main St.,<br>New York, N. Y.          |  | January 10, 1917   |  |
| Mrs. J. B. Jones  |  | 456 Oak St.,<br>Chicago, Ill.             |  | February 15, 1917  |  |
| Dr. C. D. Brown   |  | 789 Elm St.,<br>Boston, Mass.             |  | March 20, 1917     |  |
| Prof. E. F. Green |  | 101 Pine St.,<br>Philadelphia, Pa.        |  | April 10, 1917     |  |
| Mr. G. H. White   |  | 202 Cedar St.,<br>San Francisco, Cal.     |  | May 5, 1917        |  |
| Miss I. K. Black  |  | 303 Birch St.,<br>Portland, Me.           |  | June 15, 1917      |  |
| Mr. L. M. Gray    |  | 404 Walnut St.,<br>St. Louis, Mo.         |  | July 10, 1917      |  |
| Mrs. N. O. Hall   |  | 505 Spruce St.,<br>Seattle, Wash.         |  | August 5, 1917     |  |
| Dr. P. Q. Adams   |  | 606 Maple St.,<br>Denver, Colo.           |  | September 10, 1917 |  |
| Mr. R. S. Baker   |  | 707 Elm St.,<br>Cleveland, Ohio           |  | October 15, 1917   |  |
| Miss T. U. Clark  |  | 808 Oak St.,<br>Buffalo, N. Y.            |  | November 10, 1917  |  |
| Mr. V. W. Evans   |  | 909 Pine St.,<br>Minneapolis, Minn.       |  | December 15, 1917  |  |
| Mrs. X. Y. Foster |  | 1010 Cedar St.,<br>Kansas City, Mo.       |  | January 10, 1918   |  |
| Dr. Z. A. Gibson  |  | 1111 Birch St.,<br>Omaha, Neb.            |  | February 15, 1918  |  |
| Mr. B. C. Howell  |  | 1212 Walnut St.,<br>Portland, Ore.        |  | March 20, 1918     |  |
| Miss D. E. Ingram |  | 1313 Spruce St.,<br>Tacoma, Wash.         |  | April 10, 1918     |  |
| Mr. F. G. Keith   |  | 1414 Maple St.,<br>Spokane, Wash.         |  | May 5, 1918        |  |
| Mrs. H. I. Lester |  | 1515 Elm St.,<br>Bozeman, Mont.           |  | June 15, 1918      |  |
| Dr. J. K. Martin  |  | 1616 Oak St.,<br>Helena, Mont.            |  | July 10, 1918      |  |
| Mr. L. M. Nelson  |  | 1717 Pine St.,<br>Butte, Mont.            |  | August 5, 1918     |  |
| Miss N. O. Parker |  | 1818 Cedar St.,<br>Great Falls, Mont.     |  | September 10, 1918 |  |
| Mr. P. Q. Roberts |  | 1919 Birch St.,<br>Missoula, Mont.        |  | October 15, 1918   |  |
| Mrs. R. S. Taylor |  | 2020 Walnut St.,<br>Kalispell, Mont.      |  | November 10, 1918  |  |
| Dr. S. T. Vance   |  | 2121 Spruce St.,<br>Liberty, Mont.        |  | December 15, 1918  |  |
| Mr. T. U. Ward    |  | 2222 Maple St.,<br>Glacier Park, Mont.    |  | January 10, 1919   |  |
| Miss V. W. X      |  | 2323 Elm St.,<br>West Glacier, Mont.      |  | February 15, 1919  |  |
| Mr. Y. Z. A       |  | 2424 Oak St.,<br>East Glacier Park, Mont. |  | March 20, 1919     |  |
| Mrs. B. C. D      |  | 2525 Pine St.,<br>Lake Park, Mont.        |  | April 10, 1919     |  |
| Dr. C. D. E       |  | 2626 Cedar St.,<br>Gardiner, Mont.        |  | May 5, 1919        |  |
| Mr. D. E. F       |  | 2727 Birch St.,<br>Gardiner, Mont.        |  | June 15, 1919      |  |
| Miss E. F. G      |  | 2828 Walnut St.,<br>Gardiner, Mont.       |  | July 10, 1919      |  |
| Mr. F. G. H       |  | 2929 Spruce St.,<br>Gardiner, Mont.       |  | August 5, 1919     |  |
| Mrs. G. H. I      |  | 3030 Maple St.,<br>Gardiner, Mont.        |  | September 10, 1919 |  |
| Dr. H. I. J       |  | 3131 Elm St.,<br>Gardiner, Mont.          |  | October 15, 1919   |  |
| Mr. I. J. K       |  | 3232 Oak St.,<br>Gardiner, Mont.          |  | November 10, 1919  |  |
| Miss J. K. L      |  | 3333 Pine St.,<br>Gardiner, Mont.         |  | December 15, 1919  |  |
| Mr. K. L. M       |  | 3434 Cedar St.,<br>Gardiner, Mont.        |  | January 10, 1920   |  |
| Mrs. L. M. N      |  | 3535 Birch St.,<br>Gardiner, Mont.        |  | February 15, 1920  |  |
| Dr. M. N. O       |  | 3636 Walnut St.,<br>Gardiner, Mont.       |  | March 20, 1920     |  |
| Mr. N. O. P       |  | 3737 Spruce St.,<br>Gardiner, Mont.       |  | April 10, 1920     |  |
| Miss O. P. Q      |  | 3838 Maple St.,<br>Gardiner, Mont.        |  | May 5, 1920        |  |
| Mr. P. Q. R       |  | 3939 Elm St.,<br>Gardiner, Mont.          |  | June 15, 1920      |  |
| Mrs. Q. R. S      |  | 4040 Oak St.,<br>Gardiner, Mont.          |  | July 10, 1920      |  |
| Dr. R. S. T       |  | 4141 Pine St.,<br>Gardiner, Mont.         |  | August 5, 1920     |  |
| Mr. S. T. U       |  | 4242 Cedar St.,<br>Gardiner, Mont.        |  | September 10, 1920 |  |
| Miss T. U. V      |  | 4343 Birch St.,<br>Gardiner, Mont.        |  | October 15, 1920   |  |
| Mr. U. V. W       |  | 4444 Walnut St.,<br>Gardiner, Mont.       |  | November 10, 1920  |  |
| Mrs. V. W. X      |  | 4545 Spruce St.,<br>Gardiner, Mont.       |  | December 15, 1920  |  |
| Dr. W. X. Y       |  | 4646 Maple St.,<br>Gardiner, Mont.        |  | January 10, 1921   |  |
| Mr. X. Y. Z       |  | 4747 Elm St.,<br>Gardiner, Mont.          |  | February 15, 1921  |  |
| Miss Y. Z. A      |  | 4848 Oak St.,<br>Gardiner, Mont.          |  | March 20, 1921     |  |
| Mr. Z. A. B       |  | 4949 Pine St.,<br>Gardiner, Mont.         |  | April 10, 1921     |  |
| Mrs. A. B. C      |  | 5050 Cedar St.,<br>Gardiner, Mont.        |  | May 5, 1921        |  |
| Dr. B. C. D       |  | 5151 Birch St.,<br>Gardiner, Mont.        |  | June 15, 1921      |  |
| Mr. C. D. E       |  | 5252 Walnut St.,<br>Gardiner, Mont.       |  | July 10, 1921      |  |
| Miss D. E. F      |  | 5353 Spruce St.,<br>Gardiner, Mont.       |  | August 5, 1921     |  |
| Mr. E. F. G       |  | 5454 Maple St.,<br>Gardiner, Mont.        |  | September 10, 1921 |  |
| Mrs. F. G. H      |  | 5555 Elm St.,<br>Gardiner, Mont.          |  | October 15, 1921   |  |
| Dr. G. H. I       |  | 5656 Oak St.,<br>Gardiner, Mont.          |  | November 10, 1921  |  |
| Mr. H. I. J       |  | 5757 Pine St.,<br>Gardiner, Mont.         |  | December 15, 1921  |  |
| Miss I. J. K      |  | 5858 Cedar St.,<br>Gardiner, Mont.        |  | January 10, 1922   |  |
| Mr. J. K. L       |  | 5959 Birch St.,<br>Gardiner, Mont.        |  | February 15, 1922  |  |
| Mrs. K. L. M      |  | 6060 Walnut St.,<br>Gardiner, Mont.       |  | March 20, 1922     |  |
| Dr. L. M. N       |  | 6161 Spruce St.,<br>Gardiner, Mont.       |  | April 10, 1922     |  |
| Mr. M. N. O       |  | 6262 Maple St.,<br>Gardiner, Mont.        |  | May 5, 1922        |  |
| Miss N. O. P      |  | 6363 Elm St.,<br>Gardiner, Mont.          |  | June 15, 1922      |  |
| Mr. O. P. Q       |  | 6464 Oak St.,<br>Gardiner, Mont.          |  | July 10, 1922      |  |
| Mrs. P. Q. R      |  | 6565 Pine St.,<br>Gardiner, Mont.         |  | August 5, 1922     |  |
| Dr. Q. R. S       |  | 6666 Cedar St.,<br>Gardiner, Mont.        |  | September 10, 1922 |  |
| Mr. R. S. T       |  | 6767 Birch St.,<br>Gardiner, Mont.        |  | October 15, 1922   |  |
| Miss S. T. U      |  | 6868 Walnut St.,<br>Gardiner, Mont.       |  | November 10, 1922  |  |
| Mr. T. U. V       |  | 6969 Spruce St.,<br>Gardiner, Mont.       |  | December 15, 1922  |  |
| Mrs. U. V. W      |  | 7070 Maple St.,<br>Gardiner, Mont.        |  | January 10, 1923   |  |
| Dr. V. W. X       |  | 7171 Elm St.,<br>Gardiner, Mont.          |  | February 15, 1923  |  |
| Mr. W. X. Y       |  | 7272 Oak St.,<br>Gardiner, Mont.          |  | March 20, 1923     |  |
| Miss X. Y. Z      |  | 7373 Pine St.,<br>Gardiner, Mont.         |  | April 10, 1923     |  |
| Mr. Y. Z. A       |  | 7474 Cedar St.,<br>Gardiner, Mont.        |  | May 5, 1923        |  |
| Mrs. Z. A. B      |  | 7575 Birch St.,<br>Gardiner, Mont.        |  | June 15, 1923      |  |
| Dr. A. B. C       |  | 7676 Walnut St.,<br>Gardiner, Mont.       |  | July 10, 1923      |  |
| Mr. B. C. D       |  | 7777 Spruce St.,<br>Gardiner, Mont.       |  | August 5, 1923     |  |
| Miss C. D. E      |  | 7878 Maple St.,<br>Gardiner, Mont.        |  | September 10, 1923 |  |
| Mr. D. E. F       |  | 7979 Elm St.,<br>Gardiner, Mont.          |  | October 15, 1923   |  |
| Mrs. E. F. G      |  | 8080 Oak St.,<br>Gardiner, Mont.          |  | November 10, 1923  |  |
| Dr. F. G. H       |  | 8181 Pine St.,<br>Gardiner, Mont.         |  | December 15, 1923  |  |
| Mr. G. H. I       |  | 8282 Cedar St.,<br>Gardiner, Mont.        |  | January 10, 1924   |  |
| Miss H. I. J      |  | 8383 Birch St.,<br>Gardiner, Mont.        |  | February 15, 1924  |  |
| Mr. I. J. K       |  | 8484 Walnut St.,<br>Gardiner, Mont.       |  | March 20, 1924     |  |
| Mrs. J. K. L      |  | 8585 Spruce St.,<br>Gardiner, Mont.       |  | April 10, 1924     |  |
| Dr. K. L. M       |  | 8686 Maple St.,<br>Gardiner, Mont.        |  | May 5, 1924        |  |
| Mr. L. M. N       |  | 8787 Elm St.,<br>Gardiner, Mont.          |  | June 15, 1924      |  |
| Miss M. N. O      |  | 8888 Oak St.,<br>Gardiner, Mont.          |  | July 10, 1924      |  |
| Mr. N. O. P       |  | 8989 Pine St.,<br>Gardiner, Mont.         |  | August 5, 1924     |  |
| Mrs. O. P. Q      |  | 9090 Cedar St.,<br>Gardiner, Mont.        |  | September 10, 1924 |  |
| Dr. P. Q. R       |  | 9191 Birch St.,<br>Gardiner, Mont.        |  | October 15, 1924   |  |
| Mr. Q. R. S       |  | 9292 Walnut St.,<br>Gardiner, Mont.       |  | November 10, 1924  |  |
| Miss R. S. T      |  | 9393 Spruce St.,<br>Gardiner, Mont.       |  | December 15, 1924  |  |
| Mr. S. T. U       |  | 9494 Maple St.,<br>Gardiner, Mont.        |  | January 10, 1925   |  |
| Mrs. T. U. V      |  | 9595 Elm St.,<br>Gardiner, Mont.          |  | February 15, 1925  |  |
| Dr. U. V. W       |  | 9696 Oak St.,<br>Gardiner, Mont.          |  | March 20, 1925     |  |
| Mr. V. W. X       |  | 9797 Pine St.,<br>Gardiner, Mont.         |  | April 10, 1925     |  |
| Miss W. X. Y      |  | 9898 Cedar St.,<br>Gardiner, Mont.        |  | May 5, 1925        |  |
| Mr. X. Y. Z       |  | 9999 Birch St.,<br>Gardiner, Mont.        |  | June 15, 1925      |  |
| Mrs. Y. Z. A      |  | 10000 Walnut St.,<br>Gardiner, Mont.      |  | July 10, 1925      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

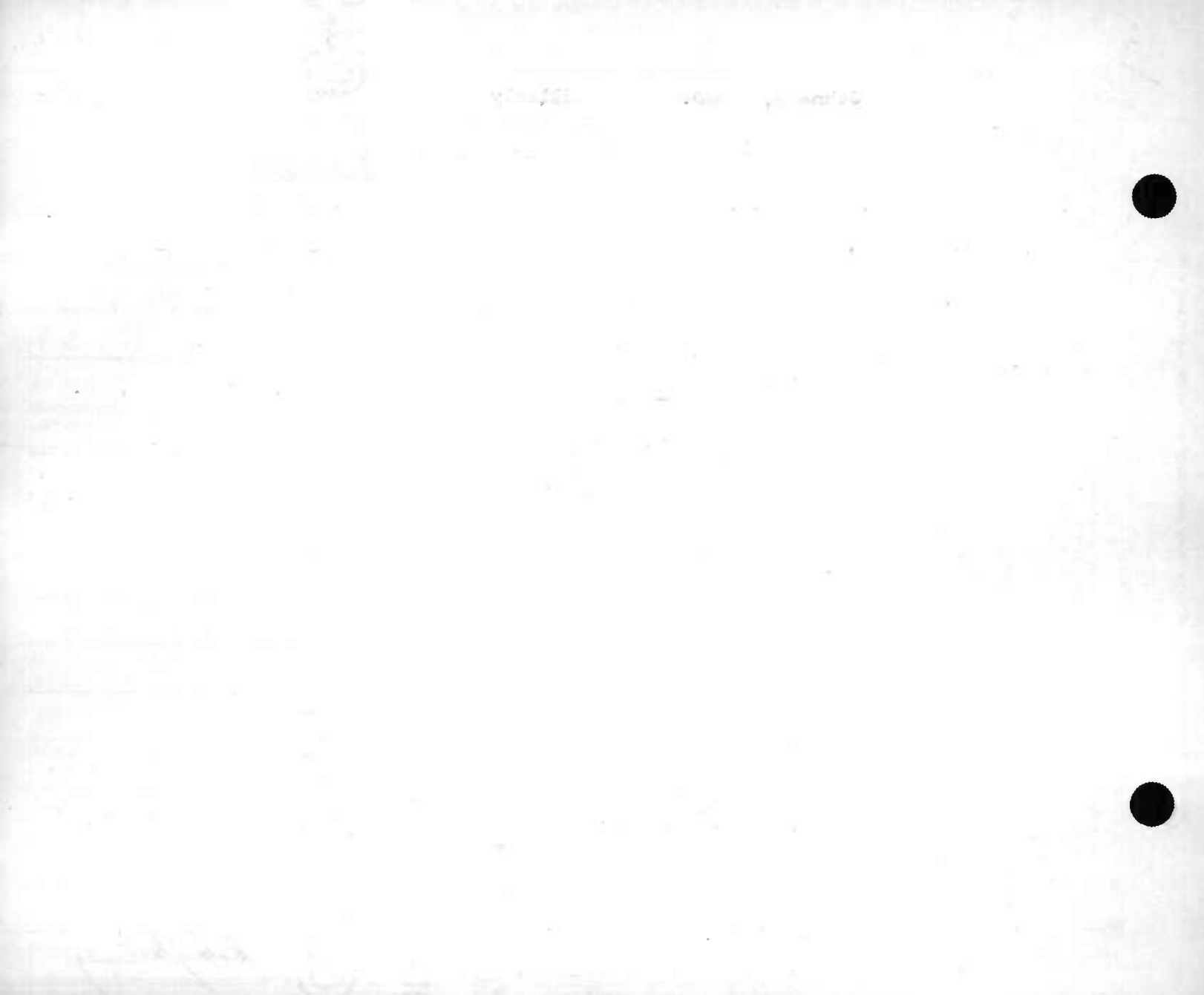
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  | 8100409  |  |  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| John J. Gillooly  |  |  |  |  |  |   |  | 1/14/81   |  | 6:05 PM                                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male  |  | White  |  | 3 - 03 - 04  |  | 76 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Md.   |  | U.S.   |  |  |  | Baltimore County MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| Catonsville,  |  | Tawes Nursing Center   |  | Patient  |  | Hospital  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS                          |  |
| Md.   |  |  |  | Baltimore  |  |   |  | 1323 Hillman Street   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |   |  |  |  |
| James Gillooly  |  | Anna McAvoy  |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |  |  |
| No  |  | N/A  |  | 213-68-5049  |  | Tawes Medical Records, Catonsville, Md.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CHARNIC Arrest</u>  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>  |  |  |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| Thomas A. P. Hannon   |  | MD   |  |  |  |   |  | 1/14/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |  |  |
| Thomas A. P. Hannon   |  |  |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| Burial  |  | 1/16/81  |  | Meadowridge Mem Pk   |  | Elkridge Howard, Md.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| MacNabb Funeral Home  |  | Catonsville, Md.   |  | JAN 22 1981  |  | Rafay McBrady   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

DHM-16 30M 2/80  
(VRA 15, 4)

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(M)

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO.<br>81 00410   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|----------|--|--|---|--|--|--|--|-----------------------------------|--|--|--|--|--------------------------------|--|--|--|--|--------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |  |  |  | 2b. HOUR |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 3. SEX   |  |  |  |  | 4. RACE  |  |          |  |  | 5. DATE OF BIRTH MONTH DAY YEAR                                     |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  | 7. IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| RICHARD E. GLENN  |  |  |  |  | Male   |  |  |  |  | White  |  |          |  |  | April 16, 1924  |  |  |  |  | 56                                |  |  |  |  | YRS.                           |  |  |  |  |                                |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |          |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| Nebraska  |  |  |  |  | USA  |  |  |  |  |  |  |          |  |  | Baltimore County MD   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |  |          |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| Towson  |  |  |  |  | Greater Balto. Medical Center  |  |  |  |  |  |  |          |  |  | Engineer  |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |          |  |  |   |  |  |  |  | 13e. STREET ADDRESS               |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 13a. STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |          |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 1722 Charmuth Road                |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| Md.   |  |  |  |  | Balto.   |  |  |  |  | Timonium   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| Maximillian Glenn   |  |  |  |  |  |  |  |  |  | Allise Neilson   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  |          |  |  | 17. INFORMANT ADDRESS   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| yes   |  |  |  |  |  |  |  |  |  | WW 2   |  |          |  |  | 359-12-0054   |  |  |  |  | Mrs. Doris S. Glenn same          |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Confluent bronchopneumonia</u>   |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 5712 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| (b) <u>Laennec's cirrhosis of liver</u>   |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| Anoxic brain damage and acute myocardial infarct  |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY?  |  |          |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |          |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
|   |  |  |  |  | P.M. 19  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> , 19 <u>80</u> , to <u>1/9</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. A (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | DEGREE   |  |          |  |  | 22c. DATE SIGNED  |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| <i>R. Breiteneker</i>   |  |  |  |  |  |  |  |  |  |  |  |          |  |  | 1/9/81  |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| R. Breiteneker, M. D.   |  |  |  |  |  |  |  |  |  | 6701 North Charles Street 21204  |  |          |  |  |   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |          |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| Cremation   |  |  |  |  | Jan. 12, 1981  |  |  |  |  | Loudon Park  |  |          |  |  | Baltimore Md.   |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |          |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |
| Ruck Towson Funeral Home Inc. Towson, Md.   |  |  |  |  |  |  |  |  |  | JAN 12 1981  |  |          |  |  | <i>Rufus McBrady</i>  |  |  |  |  |                                   |  |  |  |  |                                |  |  |  |  |                                |  |  |  |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 00411

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILTON S. GOLDBLOOM</b>                    |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 18, 81</b>                              |  | 2b. HOUR<br><b>5P</b> M                             |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC. 23, 1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                              |   |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ATTORNEY</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT LAW</b>  |
| 13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br><b>3313 LAURI RD. #21207</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MORRIS GOLDBLOOM</b>                 |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH STREETT</b>               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-38-2505</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. ROSE GOLDBLOOM</b><br><b>3313 LAURI RD. BALTO., MD 21207</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardio-respiratory arrest*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH1739  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *metastatic carcinoma of the skin*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

*ASCA*

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 6, 1980</b> to <b>Jan 18, 1981</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 18, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><i>Sharon Pourmetabed M.D.</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-18-81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHASSEM POURMETABED</b>   |  |  | 22e. ADDRESS<br><b>Balto. County Gen Hospital</b>                              |   |   |

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  | 23b. DATE<br><b>JAN. 19, 1981</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE BALTIMORE MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1981</b>       | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia H. Brady</i>                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

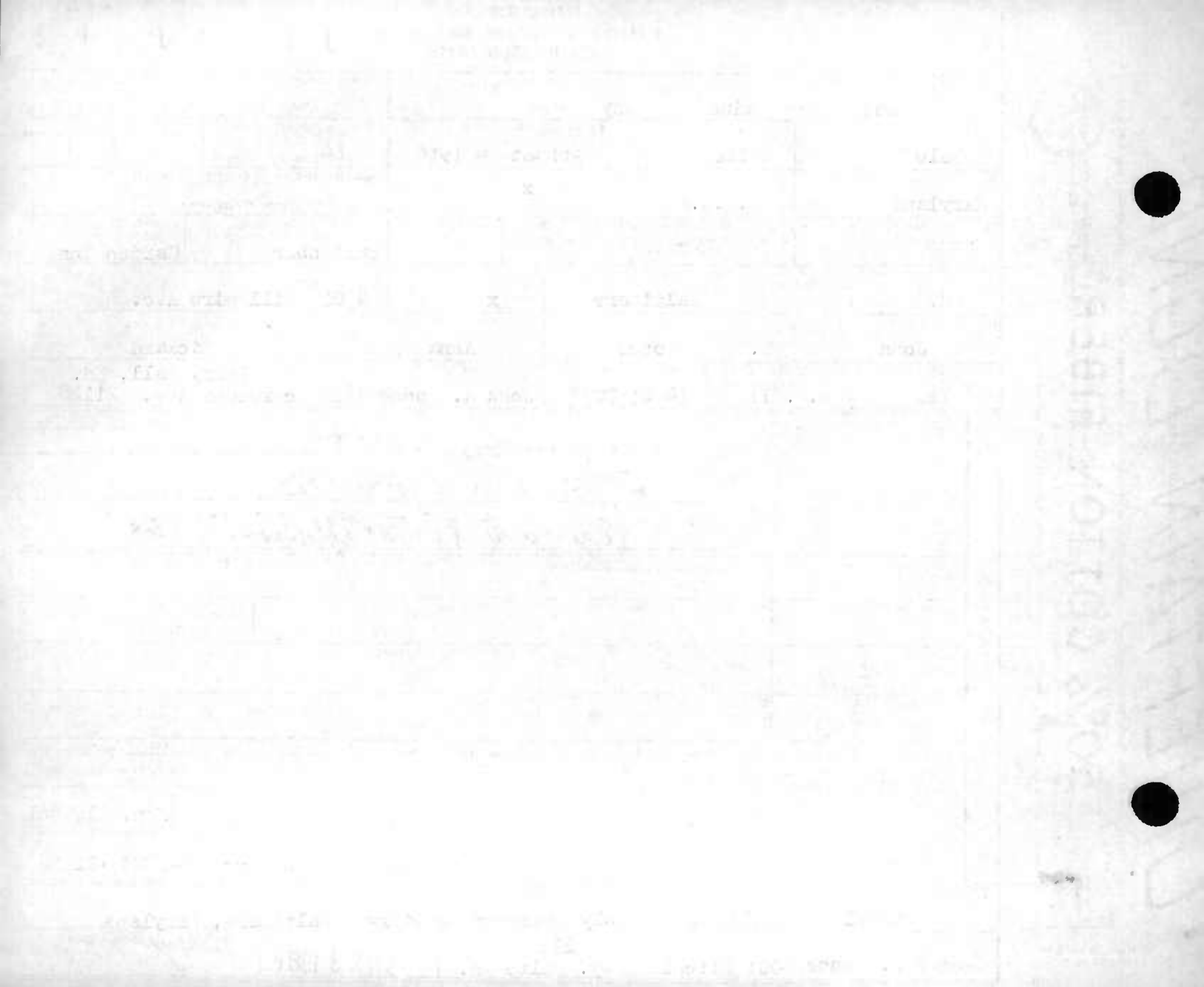
1901 18 HAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  | 8 1 00412<br>REG. NO.  |  |   |  |                               |  |                            |  |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|-------------------------------|--|----------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Andrew Ignatius Anthony Gonce</b>  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 21, 1981</b> |  |                               |  | 2b. HOUR<br><b>5:56am.</b> |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 24 1916</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                    |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                              |  | IF UNDER 24 HRS<br>HOURS MIN. |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |  |   |  |                               |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bartender</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Garden Inn</b>      |  |                               |  |                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS<br><b>4302 Willshire Ave.</b>                                    |  |  |   |  |                               |  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John T. Gonce</b>  |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Dickard</b>  |  |  |  |  |  |   |  |                               |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. II</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>Perry Hall, Md.</b><br><b>John A. Gonce 3822 Schroeder Ave. 21128</b>  |  |  |  |  |  |   |  |                               |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>5719</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Hypoxemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hypoxemia &amp; ASCUD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Age- and pleural effusions of ? Etiology</b><br>(c) <b>Age- and pleural effusions of ? Etiology</b> |  |  |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |                               |  |                            |  |
|   |  |  |   |  |  |   |  |  |  |  |  |   |  |                               |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |  |  |  |   |  |                               |  |                            |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                               |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |  |                               |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |                               |  |                            |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>Jan. 11, 1981</b> to <b>Jan. 21, 1981</b> , that (X) (we) lost<br>saw the deceased alive on <b>Jan. 21, 1981</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |   |  |                               |  |                            |  |
| 22b. SIGNATURE<br><b>L. Boas</b>  |  |  |   |  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>Jan. 21, 1981</b>   |  |  |  |   |  |                               |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Boas, M.D.</b>   |  |  |   |  |  | 22e. ADDRESS<br><b>50 Scott Adam Rd. Cockeysville, Md. 21030</b>  |  |  |  |  |  |   |  |                               |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |   | 23b. DATE<br><b>1/24/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |   |  |                               |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  |  |   |  |  | ADDRESS<br><b>4001 Ritchie Hwy. Balto Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1981</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |                               |  |                            |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |                                      |   |                     |
|---|--|---|--------------------------------------|---|---------------------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH                                       |                                      | 2b. HOUR  |                     |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE KNOWN OF DEATH                                       |                                      | 2b. HOUR  |                     |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR  |                                      | HOUR  |                     |
| Joseph Mayhew Goppy   |  | 1 6 19 81   |                                      | 12 45   |                     |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)                    | 7. IF UNDER 1 YR.   | 8. IF UNDER 24 HRS. |
| male  | black  | MONTH DAY YEAR  | LAST BIRTHDAY                        | MONTHS DAYS   | HOURS MIN.          |
|   |  | 3 19 53   | 27 YRS.                              |   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                     |
| St. Agusta Trinidad   |  | WIDOWED NEVER MARRIED   | Baltimore County                     |   |                     |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY    |   |                     |
| Woodlawn  | 6753 Townbrook Drive                                     | unemp.  |                                      |   |                     |
| 13a. STATE  | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?                                      | 13e. STREET ADDRESS                  |   |                     |
| MD.   | Baltimore  | YES NO  | 6753 Townbrook Drv. Woodlawn Md.     |   |                     |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                 |   |                                      |   |                     |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  |   |                                      |   |                     |
|   | Sybil Goppy  |   |                                      |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  | 16b. SOCIAL SECURITY NO.                                 | 17. INFORMANT   | ADDRESS                              |   |                     |
| (YES, NO, OR UNKNOWN)   | (IF YES, GIVE WAR OR DATES)                              |   |                                      |   |                     |
| No  | 213-88-0114  | M's. Arlene Neale   | 5400 Lynview Ave.                    |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |                                      |   |                     |
| PART I DEATH WAS CAUSED BY:   |  |   |                                      |   |                     |
| IMMEDIATE CAUSE (a) Asphyxia  |  |   |                                      |   |                     |
| 9530  |  |   |                                      |   |                     |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |                                      |   |                     |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |                                      |   |                     |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |   |                                      |   |                     |
| (c)   |  |   |                                      |   |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |                                      |   |                     |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |                                      | 20. AUTOPSY?  |                     |
|   |  |   |                                      | YES NO  |                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                     |
|   |  | Est. HOUR A.M. MONTH DAY YEAR                                 |                                      |   |                     |
|   |  | ? P.M. 1/6/ 19 81   |                                      | from hanging by neck  |                     |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                      | 21f. LOCATION   |                     |
|   |  | house   |                                      | 6753 Apt D, Townbrook, Woodlawn, Balto Co., MD                                |                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection, Inquiry, and in my opinion death resulted from: Maternal causes Accident Suicide Homicide Undetermined manner |  |   |                                      |   |                     |
| Actual Signature: [Signature] M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1/7/81  |  |   |                                      |   |                     |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201   |  |   |                                      |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY  |                     |
| Burial  |  | 1/12/81   |                                      | Family Lot  |                     |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D BY REGISTRAR                                  |                                      | 25b. REGISTRAR'S SIGNATURE  |                     |
| Teroy O. Dyett and Son  |  | JAN 8 1981  |                                      | [Signature]   |                     |

664 6800



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8100414  |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>[TYPE OR PRINT] <b>EDNA E. GRAHAM</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-3-81</b>  |  |  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 16 1898</b>  |  | 6. AGE [IN YEARS LAST BIRTHDAY]<br><b>82</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Gen. Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Harford</b> 13c. CITY OR TOWN <b>Joppa</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lawrence Barnes</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann Skinner</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>232-10-1852</b>  |  | 17. INFORMANT<br><b>Odis E. Graham</b>  |  | ADDRESS <b>734 Stengel Ave. Balto. MD. 21222</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>4860</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-3-1981</b> to <b>1-3-1981</b> , that (I) (we) lost saw the deceased alive on <b>1-3-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Soonchul Hong</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1-3-81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOONCHUL HONG</b>  |  |   |  | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1/5/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |



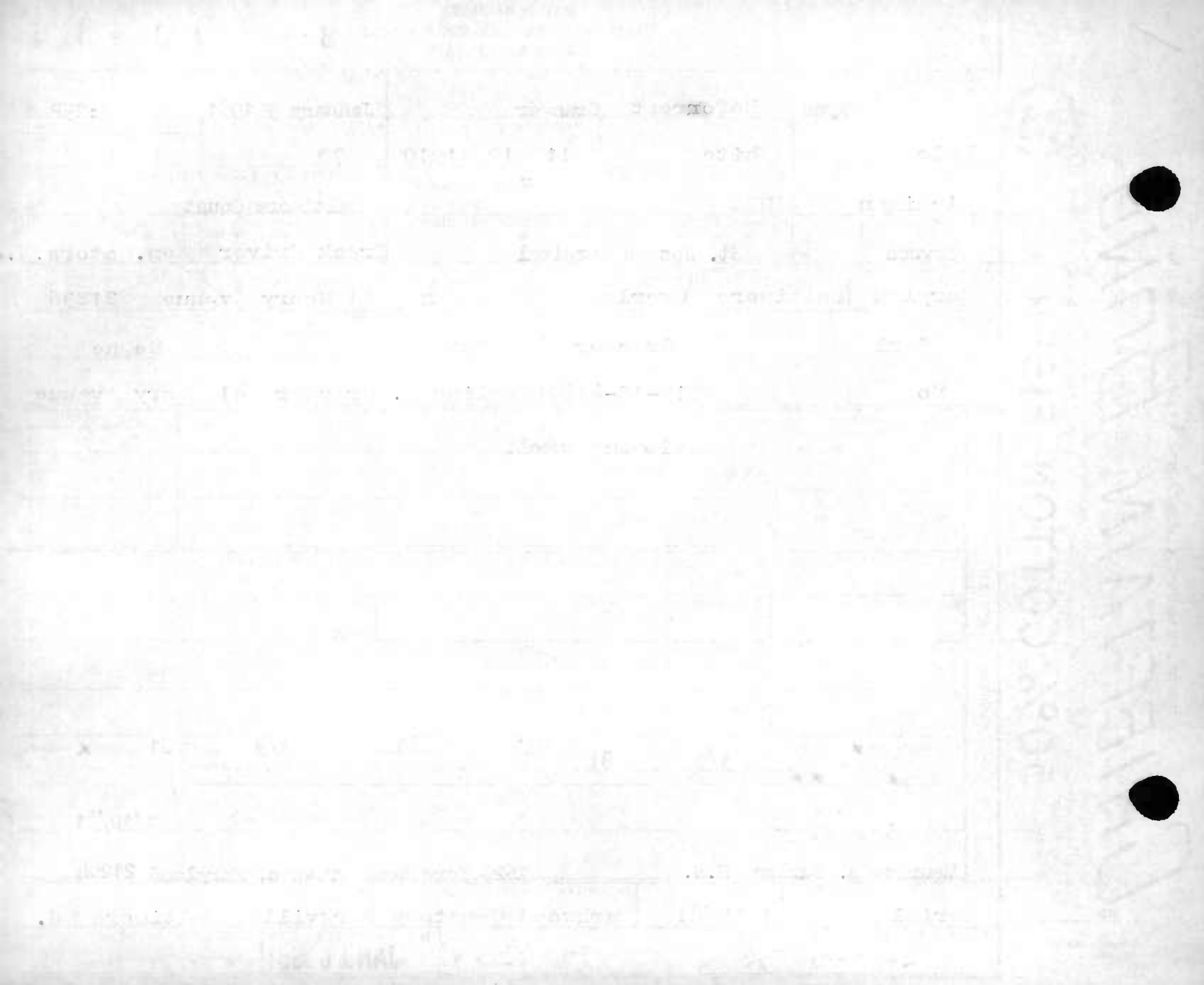
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |  |   | 8100415                                      |  |
|---|--|--|---|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | REG. NO.   |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Wayne DeForrest Granger</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 9 1981</b>                      |  |  |  | 2b. HOUR<br><b>7:25P M.</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 19 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen. Motors, N.</b>  |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>                                     |   | 13c. CITY OR TOWN<br><b>Overlea</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>41 Henry Avenue 21236</b>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Earl Granger</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary DePue</b>                |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-4187</b>                      |   | 17. INFORMANT ADDRESS<br><b>Pauline M. Granger 41 Henry Avenue</b>             |  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Emboli</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |   |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/5</b> , 19 <b>80</b> , to <b>1/9</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.   |  |  |   |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><i>M. B. Furlong</i>  |  |  |   |   | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/10/81</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Maurice B. Furlong M.D.</b>   |  |  |   |   | 22e. ADDRESS<br><b>7620 York Road Towson, Maryland 21204</b>                   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/13/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                 |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Lassah F/A</b>  |  |  |   |   | ADDRESS<br><b>7401 Belair Rd</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar rather than with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 81 00416  |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET GRAUEL</b>  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/27/81</b>   |  | 2b. HOUR<br><b>9:05PM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 12, 1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TOWSON Balto. Co. MD.</b>                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Practical Nurse</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>615 Chestnut Avenue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Chesney</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Myrtle Michael</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-22-7644</b>  |  | 17. INFORMANT ADDRESS<br><b>Pickersgill Home 615 Chestnut Avenue</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br><b>4100 IMMEDIATE CAUSE (a) CARDIAC ARREST</b>  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5-22 min</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PROB MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Serial heart</b>   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>1/30, 1969</b> , to <b>1/27, 1981</b> , that (I) (we) lost saw the deceased alive on <b>1/27, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (and) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Frank Supplee, Jr.</b>  |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>1/28/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR J FRANK SUPPLEE</b>  |  |  |  | 22e. ADDRESS<br><b>1010 ST PAUL ST BALTO. 21202</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1-28-1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |  |  | ADDRESS<br><b>1050 York Road Towson, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruthy McCreedy</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 4 1 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |   |  |  |  |  |  |
|--|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harry Green</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 10, 1981</b> |   |   | 2b. HOUR <b>5:30 A.M.</b>  |  |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 30 05</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.                     |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Mt. Wilson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mt. Wilson Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>   |  |  |
| 13a. STATE <b>MD</b>   |  |  |   |   | 13b. COUNTY <b>Prince George's</b>                                |  | 13c. CITY OR TOWN <b>Silver Spring</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Cornelius Green</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Clara Driver</b> |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>-</b>   |   | 17. INFORMANT ADDRESS <b>Center</b><br><b>Mt. Wilson Lane, Mt. Wilson, MD 21112</b>   |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4075</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> |  |  |   |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Decubitus Ulcers, Organic Brain Syndrome</b>   |  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Apr 2, 1973</b> to <b>Jan 10, 1981</b> , that (we) lost<br>saw the deceased alive on <b>Jan. 10, 1981</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death.   |  |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James H. Milner</b>   |  |  |   | DEGREE <b>MD.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  | 22c. DATE SIGNED<br><b>1-10-81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James H. Milner, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>University of Md. Hospital, Baltimore, Md.</b>   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>1/13/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Pk</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westview Baltimore MD</b>           |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, P.A.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Loring Byers</b>                                    |  |  |  |  |
| 24. ADDRESS<br><b>8728 Liberty Rd., Randallstown, MD 21133</b>   |  |  |   |   |   |  |  |  |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR 15 ME 1)  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |  |  |  |  |  | REG. NO. 00418  |  |
|---|--|----------------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Robert Mason Green, Jr</b>  |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>25</b> YEAR <b>1981</b> |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>18</b> YEAR <b>1950</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.                     |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7b. HOUR <b>M</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 7c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>25</b> YEAR <b>1981</b>                                    |  |
| 10. CITY OR TOWN OF DEATH <b>Parkton</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Middletown Rd/Bulls Sawmill Rd</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Pennsylvania</b>  |  |                      |  | 13b. COUNTY <b>Glen Rock</b>  |  | 13c. CITY OR TOWN <b>Glen Rock</b>                                 |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>RD 3 Box 69 Glen Rock, Pa.</b>   |  |
| 14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Mason</b> LAST <b>Green</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Dorothea</b> MIDDLE <b>M.</b> LAST <b>Sellick</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>215-54-3719</b>   |  | 17. INFORMANT ADDRESS <b>Mr. Robert M. Green 4145 Madonna Road</b> |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Multiple injuries</b><br>IMMEDIATE CAUSE (a) <b>8150</b><br>(b) <b>8150</b><br>(c) <b>8150</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:15xx 1/25 1981</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/fixed object/ejected collision</b>                       |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>  |  |  |  | 21f. LOCATION STREET <b>Middletown Rd/Bulls Sawmill Rd,</b> CITY OR TOWN <b>Balto</b> COUNTY <b>Co</b> STATE <b>MD</b>                                   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>H. Guard</b>  |  |                      |  | M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>1/25/81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |                      |  | 23b. DATE <b>1-26-1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>              |  |  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>Towson, Maryland</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b>                   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

1924

RESEARCH

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00419

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Florence

GREGORY

2a. DATE KNOWN OF DEATH  
ESTIMATED DATE MATED 1-26-81 10:00 AM

2b. HOUR

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS)

BIRTHDAY

IF UNDER 1 YR.

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7c. DATE

Pronounced

DEAD

MONTH

DAY

YEAR

2d. HOUR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 0 0 4 2 0  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR   |  |   |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR  |  |  |  | MONTH DAY YEAR   |  |   |  |
| William Howard Grenzer, Sr.  |  |  |  | January 30, 1981  |  |  |  | 10:00 <sup>A</sup>   |  |   |  |
| 1. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  |
| Male   |  | White  |  | 3 17 1910   |  | 70 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |   |  |
| Maryland   |  | USA  |  |   |  | Baltimore County MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| Timonium   |  | 2119 Pot Spring Road, Timonium   |  |   |  |  |  | Internal Medicine  |  | Medical   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |
| Md.  |  |  |  | Balto.  |  | Timonium   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 2119 Pot Spring Road  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST   |  |  |  |  |  |   |  |
| Louis Eberhardt Grenzer  |  |  |  | Annie Trischman   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |
| No   |  |  |  | 215-12-7418   |  | Mrs. Anna B. Grenzer, 2119 Pot Spring Rd                                       |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic cardiovascular disease</u><br><u>Years</u>                |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>7 months</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>Diverticulitis, Emphysema, Cholecystitis</u>  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  |
|  |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
| 22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>Jan. 30</u> , 19 <u>81</u> , to <u>Jan. 30</u> , 19 <u>81</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Jan. 30</u> , 19 <u>81</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |  |  | 22b. SIGNATURE<br><u>Louis E. Grenzer</u><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Louis E. Grenzer, M. D.   |  |  |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>2/1/81</u>                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  |  |  | 23b. DATE<br><u>2/2/81</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Dulaney Valley Cem.</u>               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Cockeysville, Maryland</u>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Martin D. Lawson</u><br>24a. ADDRESS<br>Martin D. Lawson, 10 W. Padonia Rd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 2 1981</u>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |

MEDICAL CERTIFICATION

29





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |   |  |  | REG. NO.<br>8100421                          |  |
|--|--|---|--|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  | 2a. DATE OF DEATH   |  |   |  |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Ella M. GRESSLER   |  |   |  |  | January 16, 1981  |  |   |  |  | 3:00 P.M.                                    |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>Feb. 5, 1900  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>80   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7. IF UNDER 74 HRS<br>HOURS MIN.             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                          |   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fiber worker         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fiber   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Delaware New Castle Newark   |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>12 E. Cleveland Ave. |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Croft   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Ober                                     |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>170-12-2783  |  | 17 INFORMANT ADDRESS<br>Fallston, Md.<br>William Aucker 713 Sharps Court, 2104   |   |  |   |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>2639 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypoglycemia<br>DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition                                |  |   |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. accident<br>Congestive heart failure; leaking gastrostomy, status post cerebrovascular  |  |   |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 29, 1980, to January 16, 1981, that I (we) last saw the deceased alive on January 16, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Robert J. Tretola M.D.   |  |   |  | DEGREE   |   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/16/81                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert J. Tretola, M.D.   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/19/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenwood Cem.   |   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Blair, Penna.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Robert T. Jones Newark, Del.   |  |   |  | 25. DATE FILED BY REGISTRAR IN REGISTRAR'S OFFICE  |   |  |   |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 0 0 4 2 2   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Elsie M. Grimes   |  |   |  | 2a. DATE OF DEATH<br>1 21 81  |  |  |  |
| 3 SEX<br>Female   |  |   |  | 7b. HOUR<br>1:05 P.   |  |  |  |
| 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 28 88  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>1 23   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Villa Nursing Cntr. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13b. STREET ADDRESS   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>5508 Edmondson Ave.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Otho Fleming  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cordelia Mullinix  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-58-9341   |  | 17. INFORMANT ADDRESS<br>Albert Grimes 5508 Edmondson Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of breast with</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastases</i><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <i>1/20</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Elmo Gayoso</i>  |  |   |  | DEGREE<br><i>M.D.</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elmo Gayoso, M. D.   |  |   |  | 22e. ADDRESS<br>5411 Old Frederick Rd.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1-24-1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Taylorsville  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Taylorsville, Carroll, Md  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles W. Burrier, Jr., Sykesville, Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1981  |  |  |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR<br>STATE<br>REGISTRAR   |                         | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH       |  | 8 1 0 0 4 2 3<br>REG. NO.   |   |
|--|-------------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT Jacob GROSHANS</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 12 81</b>                  |   | 2b. HOUR<br><b>1234p</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 25 1896</b>                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>84 Balto. Co.</b> MD  |                         | 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b>                |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Civil Engr. Balto. G &amp; E</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>   |                         |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Perry Hall</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Frederick Greshans</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia W Kregg</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>WW I</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Myrtle E. Greshans 9210 Hines Road</b>   |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>5742 Acute Myocardial infarction</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Suprapubic</b> |                         |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Cholecystitis 1980 Cholelithiasis 1980</b>  |                         |  |  |   |   |
| 19a. DATE OF OPERATION<br><b>Dec 1980</b>  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cholelithiasis - cystolithiasis</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         |  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                         |  |  |   |   |
| 22b. SIGNATURE<br><b>Juan G. Ganu</b>  |                         | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/12/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JUAN G. GAN</b>  |                         | 22e. ADDRESS<br><b>2311 RAVENVIEW RD. 21093</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>1/15/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>   |                         |  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |                         | ADDRESS<br><b>7401 Belair Road</b>   |  |   |   |

UNITED STATES  
DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "TO:" and "FROM:" are visible.]*

1/17/61

John O. Carr, Esq.  
19 West Main St.  
New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  | REG. NO. 8. 1 0 0 4 2 4  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET E GROTZKY</b>   |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 23, 1981</b>   |  | 2b. HOUR<br><b>6:45am</b>  |  |
| 3. SEX<br><b>F Female</b>   |  | 4. RACE<br><b>Caucasian White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 9 1891</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b. UNDER 24 HRS<br>HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>AA Co., Md.</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.  |  |   |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Summit Nursing Home</b> |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>C &amp; P Tel. Co.</b>   |  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>Md.</b>   |  | 16b. COUNTY<br><b>Balto.</b>  |  | 16c. CITY OR TOWN<br><b>Catonsville</b>  |  | 16d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 17. STREET ADDRESS<br><b>10 Shady Nook Drive</b>  |  |  |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Archibald Johnson</b>  |  |   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret A. Warfield</b>   |  |  |  | 20. ADDRESS<br><b>Glen Burnie, Md.</b>  |  |  |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 22. SOCIAL SECURITY NO.<br><b>217-22-9474</b>   |  | 23. INFORMANT<br><b>Mary E. Stinchcomb, 614 Glenview</b>   |  |  |  |   |  |  |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br><b>9299 Original thrombosis left</b><br>IMMEDIATE CAUSE (a) <b>in</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>UTI Septicemia</b> (b) <b>in</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>Fract Hip Rt old</b> (c) <b>in</b><br><b>Multiple Contractures Extremities</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><b>Shingles face left old</b> (d) <b>in</b> |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4/6/81</b><br><b>1976</b><br><b>1976</b><br><b>1976</b> |  |
| 25. DATE OF OPERATION<br><b>9/9/79</b>  |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 33. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 34. LOCATION<br>STREET<br><b>1976</b>  |  | 35. CITY OR TOWN<br><b>1/23/81</b>   |  | 36. COUNTY<br><b>Baltimore</b>  |  |  |  |
| 37. I certify that (I) (this hospital) attended the deceased from <b>1/6/81</b> to <b>1/23/81</b> , that (I) (we) last saw the deceased alive on <b>1/6/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  | 38. SIGNATURE<br><b>Dr. Mc Grath</b>   |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W E Mc Grath M.D.</b>  |  | 40. ADDRESS<br><b>1303 Frederick Rd Catonsville</b>   |  | 41. DATE SIGNED<br><b>1/23/81</b>  |  | 42. ATTENDING PHYSICIAN<br>MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |  |  |
| 43. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |  | 44. DATE<br><b>24 Jan. 81</b>   |  | 45. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  | 46. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |  | 47. COUNTY<br><b>Baltimore</b>  |  |  |  |
| 48. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley</b>   |  | 49. ADDRESS<br><b>Glen Burnie, Md.</b>  |  | 50. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1981</b>   |  | 51. REGISTERING PHYSICIAN<br><b>Anthony Mc Grath</b>   |  |   |  |  |  |



James E. Inley, Glen Burnie, Md.  
Enclosed: 24 Jan. 81 London Park  
Baltimore, Md.

717-22-2474 Mary E. Elinchomp, 64 Glenview  
Glen Burnie, Md.  
Hartfield  
Johnson  
Hartfield

10 Chesham Drive  
Glenview, Md.  
Hartfield

AN Co., Md.  
Hartfield  
Hartfield

January 27, 1981 10:45a  
101  
3789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | 8100425                                       |  |  |
|--|--|--|--|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.   |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRIE W GROVES</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1 30 81</b>                             |   | 2b. HOUR<br><b>840 am</b>                     |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 26 90</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>DELAWARE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FREDERICK VILLA Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MOVEMENT DIRECTOR</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>         |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jonathan Groves</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Allice E. Woodbury</b>     |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>A-832774-4</b>                                  |   | 17. INFORMANT<br><b>Mrs. Myrtle K. Groves</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br><b>ASHD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Seconds</b><br><b>years</b> |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>Dec 26 1981</b> to <b>1/30 81</b> , that (I) (we) last saw the deceased alive on <b>Dec 26 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>James Nolan</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 22c. DATE SIGNED<br><b>1/30/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NOLAN</b>  |  | 22e. ADDRESS<br><b>1 Mallory Hill Rd Balt Md 21229</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 2, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab 5151 Balto. National Pike Balto. Md. 21229</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |



Mr. J. L. Groves  
 6114 Wisconsin Ave. N.W.  
 Washington, D.C.

Special  
 Feb. 2, 1941  
 Mr. J. L. Groves  
 6114 Wisconsin Ave. N.W.  
 Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |  |  |  |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Antoinette E. Hagan   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 7 1981                  |   |  | 2b. HOUR<br>9:12 A.M.  |   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 25 1891   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.Y.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. 21239  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Armocost N.H. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Towson                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>6920 Donachie Rd. Apt. 1610 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francis Kalska   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Antoinette Dumas      |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>213-74-0587                                |   | 17. INFORMANT<br>Rosemary G. Stendorf            |  |   |  | ADDRESS<br>Same                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>AsVD and Demencia</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19 <u>71</u> , to <u>1/7</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Robert Mathieson M.D.  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>1/7/81   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Mathieson M.D.   |  |  | 22e. ADDRESS<br>7501 York Rd., Towson, Md. 21204                       |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1-8-81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick Fred. Md.                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co., Balto., Md.   |  |  | ADDRESS<br>4905 York Rd.   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>Robert Mathieson   |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00427

FOR  
1- STATE  
REGISTRAR

|   |                         |  |   |   |
|---|-------------------------|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Raymond Wesley Hall</i>  |                         | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <i>1</i> DAY <i>8</i> YEAR <i>1981</i>          |   | 2b. HOUR<br><i>8:50</i> AM  |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br>MONTH <i>11</i> DAY <i>19</i> YEAR <i>08</i>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>72</i> YRS. | IF UNDER 1 YR.<br>MONTHS <i>0</i> DAYS <i>0</i>   |
| 7a. BIRTHPLACE (STATE OR COUNTY)<br><i>Baltimore Co., Md.</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><i>Powder Mill</i>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NO SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Funerary Home</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Truck Driver</i>  |
| 13a. STATE<br><i>Md</i>   |                         | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. STREET ADDRESS<br><i>13217 Powder Mill Rd</i>  |
| 14. FATHER'S NAME<br>FIRST <i>James</i> MIDDLE <i>Hall</i> LAST <i>Hall</i>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Florida</i> MIDDLE <i>Johnson</i> LAST <i>Johnson</i>                                     |   | 12b. KIND OF BUSINESS<br><i>Funerary Supply Company</i>   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <i>No</i>   |                         | 16b. SOCIAL SECURITY NO.<br><i>217 05 9973</i>   |   | 17. INFORMANT<br>ADDRESS <i>Same</i>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Cardiovascular Disease</i><br><i>429.2</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>Or Dependency COPD</i>  |                         |  |   |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |   |
| ACTUAL SIGNATURE<br><i>John C. Hyle</i>   |                         | TITLE (SPECIFY)<br><i>Dfj</i>  |   | DATE SIGNED<br><i>1-9-81</i>  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <i>JOHN C. Hyle</i>  |                         | ADDRESS<br><i>7527 Belton Rd Baltimore 36 Md</i>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>Burial</i>  |                         | 23b. DATE<br><i>1/12/81</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Ebenezer Meth. Church Cemetery</i>   |
| 24. FUNERAL DIRECTOR<br><i>Bruzdzinski Funeral Home</i>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 9 1981</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia K. Brady</i>  |
| 23d. LOCATION<br>CITY OR TOWN<br><i>Chase, Md.</i>  |                         | STATE<br><i>Md.</i>  |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |   |   |   | 8 1 0 0 4 2 8                                |                             |  |
|--|--|--|---|--|--|--|---|---|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.  |  |  |  |   |   |   |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |   | 2b. HOUR A M  |  |                             |  |
| Myrtle Thompson HANCE  |  |  |   |  |  | January 9, 1981  |   |   | 1:51 M  |  |                             |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |   | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |  |
| Female   |  | White  |   | March 26, 1883   |  | 97 YRS.  |   |   |   |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |   |  |                             |  |
| Maryland   |  | U.S.A.   |   |  |  | Baltimore County MD.   |   |   |   |  |                             |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                             |  |
| Randallstown   |  | Old Court Nursing Center   |   |  |  | None   |   |   | None  |  |                             |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                                      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS   |  |                             |  |
| Maryland   |  |  | Baltimore   |  | Sparks   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   | 621 E. Belfast Road   |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |  |  |   |   |   |  |                             |  |
| Griffin  |  |  | Hebb  |  |  | Elizabeth Cecelia Thompson   |   |   |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                |  | 17. INFORMANT ADDRESS                                  |  |   |   |   |  |                             |  |
| No   |  |  | 217-54-9798   |  | Daughter: Mary Katherine H. Turnbull, Sparks, MD 21152 |  |   |   |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                             |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |  |  |   |   |   |  |                             |  |
| IMMEDIATE CAUSE (a)  |  |  |   |  |  |  |   |   |   | 3 days                                       |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |   |  |  |  |   |   |   | 20 years                                     |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |  |   |   |   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |  |   |   |   |  |                             |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |                             |  |
|  |  |  | P.M. 19   |  |  |  |   |   |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |   |   |  |                             |  |
|  |  |  |   |  |  |  |   |   |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-6-80 to 1-9-81, that (I) (we) last saw the deceased alive on 1-9-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and) not view the body after death. |  |  |   |  |  |  |   |   |   |  |                             |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |  | 22c. DATE SIGNED   |   |   |   |  |                             |  |
| MICHAEL D. FEARLMAN, M.D.  |  |  |   |  |  | 1/10/81  |   |   |   |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |  |  |   |   |   |  |                             |  |
| 5400 OLD COURT ROAD SUITE 204  |  |  | RANDALLSTOWN, MARYLAND 21133  |  |  |  |   |   |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                     |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |  |                             |  |
| Cremation  |  |  | 1/10/81   |  | Security Process                                       |  |   | Baltimore MD                            |   |  |                             |  |
| 24. FUNERAL DIRECTOR NAME  |  |  | ADDRESS   |  |  | 25a. DATE RECEIVED BY REGISTRAR  |   |   | 25b. REGISTRAR'S SIGNATURE  |  |                             |  |
| STEWART & MOWEN CO., 108 W. North Ave. 21201   |  |  |   |  |  | JAN 15 1981  |   |   |   |  |                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 81 00429<br>REG. NO.   |  |   |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Laurene M. Handy</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/ 06/ 1981</b>  |  |  |  | 2b. HOUR<br><b>4:35 A M</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1/ 09/ 1924</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS   |  | 7. UNDER 1 YEAR MONTHS DAYS  |  | 8. UNDER 24 HRS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD                                     |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6816 Yataruba Drive 21207</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Soc. Security</b>  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6816 Yataruba Drive Balto. Md.</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Raymond E. Montgomery</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Laura WARD Diggs</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>   |  | 16b. SOCIAL SECURITY NO<br><b>579-20-6963</b>  |  | 17. INFORMANT ADDRESS<br><b>Baltimore, Md.</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Ca to the Brain</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Adenocarcinoma, Primary Site, Unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 year</b>                              |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 months</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 3 1981</b> , to <b>Jan 6 1981</b> , that (I) (we) lost <b>her</b> the deceased alive on <b>Jan 3 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <b>view</b> the body after death. |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert S. Smoot M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/6/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROLAND T. SMOOT, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>2300 GARRISON BLVD 21216</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>1/10/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Cem.</b>                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Herbert E. Nutter</b>   |  |  |  | ADDRESS<br><b>3035 W. North Ave. 21216</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1981</b>  |  | 25b. SIGNATURE<br><b>Robert S. Smoot</b>   |  |   |  |

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|               |  |                |            |  |                |
|---------------|--|----------------|------------|--|----------------|
| 279-2-6963    | Harman J. Hardy 6816 Yatarba Drive 21207 | Baltimore, Md. | 279-2-6963 | Harman J. Hardy 6816 Yatarba Drive 21207 | Baltimore, Md. |
| No.           |  |                |            |  |                |
| Raymond E.    | Kondrinsky                               | Baltimore      |            |  |                |
| Maryland      | Baltimore                                |                |            |  |                |
| Baltimore     | 6816 Yatarba Drive                       | 21207          |            |  |                |
| Clerk         |  |                |            |  |                |
| Soc. Security |  |                |            |  |                |
| County        |  |                |            |  |                |
| 11 02 1934    |  |                |            |  |                |
| Handy         |  |                |            |  |                |
| 11 02 1931    |  |                |            |  |                |

Harriet E. Nutter 3035 W. North Ave. 21210  
 Daniel 1/10/1981  
 Ardus Memorial Cem. Baltimore, Md.  
 Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO. 81 00430   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>WILLIAM ALFRED HANKINS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 26 81</b>                           |   | 2b. HOUR<br><b>7:18PM</b>                              |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 15, 1926</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS MIN.<br><b>54</b>                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TOWSON</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N. CHARLES ST GBMC</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Automobile</b> |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Cedarcroft</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>906 Overbrook Rd.</b>        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ray L. Hankins</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie R. Baldwin</b>        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-16-9142</b>   |  | 17. INFORMANT ADDRESS<br><b>Clifton R. Hankins Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>1619</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RECURRENT CARCINOMA OF LARYNX</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>TRACHEO-ESOPHAGEAL FISTULA</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/1981</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF LARYNX</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 5</b> , 19 <b>81</b> , to <b>JAN 26</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>JAN 26</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert Capitelli, M.D.</b>   |  |  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR ROBERT CAPITELLI</b>   |  |  |  | 22e. ADDRESS<br><b>6701 N CHARLES SR 21204</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 29, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Pk. Parkville, Balto. Co., Md.</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  | 23e. DATE RECEIVED BY REGISTRAR (TYPE REGISTRAR'S SIGNATURE)   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Baltimore, Md.</b>   |  |  |  |   |  |

BP

Technical-Wholesale House, Inc., Baltimore, Md.

New York 24.

John E. Howard Memorial R. Hospital, Baltimore, Md.

DR. ROBERT CASTELL

DR. M. CHARLES E. 21224

JAN 28 81

JAN 2 91

JAN 28 81

CLINIC OF LARYNX

TECHNICAL-Wholesale House

CLINIC OF LARYNX  
CARDIO-RESPIRATORY ARREST

DR. M. CHARLES E. 21224

DR. ROBERT CASTELL

DR. M. CHARLES E. 21224

DR. ROBERT CASTELL

CLINIC OF LARYNX

DR. M. CHARLES E. 21224

JAN 28 81

DR. ROBERT CASTELL

DR. M. CHARLES E. 21224

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>STATE REGISTRAR   |  |                                 |  |   |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                     |  |   |  |  |  |  |  |  |  | REG. NO. 00431            |  |                           |  |
|--|--|---------------------------------|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|---------------------------|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Odin J. Hanssen</b>   |  |                                 |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>1/5</b> DAY <b>19</b> YEAR <b>81</b> |  |   |  |  |  |  |  |  |  | 2b. HOUR <b>5:00 P.M.</b> |  |                           |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>         |  | 5. DATE OF BIRTH<br>MONTH <b>Oct.</b> DAY <b>1</b> YEAR <b>1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>1/5</b> DAY <b>19</b> YEAR <b>81</b>           |  |  |  |  |  |  |  |                           |  | 2d. HOUR <b>6:30 P.M.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>California</b>   |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                  |  |  |  |  |  |  |  |                           |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>813 Platium Ave.</b> |  |   |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Co.</b>                    |  |  |  |                           |  |                           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                 |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b> |  | 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>813 Platium Avenue 21221</b>  |  |  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 14. FATHER'S NAME<br>FIRST <b>Olaf</b> MIDDLE <b>-</b> LAST <b>Hanssen</b>   |  |                                 |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jenny</b> MIDDLE <b>-</b> LAST <b>?</b>   |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>1919-1922</b>  |  | 17. INFORMANT (Son)<br><b>Raymond Hanssen</b>   |  |   |  | ADDRESS<br><b>311 N. Marlyn Ave. Baltimore, Md. 21221</b>  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Cardiovascular arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                   |  |                                 |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                 |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 19a. DATE OF OPERATION   |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                           |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                 |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| ACTUAL SIGNATURE <b>K. S. Ahluwalia</b>  |  |                                 |  | TITLE (SPECIFY) <b>Regent</b>   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>1/7/81</b>   |  |  |  |  |  |  |  |                           |  |                           |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>K. S. AHLUWALIA</b>   |  |                                 |  | ADDRESS <b>2113 Dundalk Ave. Balt. 21222</b>  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                                 |  | 23b. DATE <b>1-9-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Mem. Gardens</b>                               |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore County, Maryland</b> COUNTY STATE   |  |   |  |  |  |  |  |  |  |                           |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Brudzinski Funeral Home</b> ADDRESS <b>PA 1407 Old Eastern Ave.</b>  |  |                                 |  |   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 9 1981</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Jeffrey H. Brady</b> |  |  |  |  |  |                           |  |                           |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |  | REG. NO. 81 00432  |  |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>BEVERLY LORRAINE HARLEY</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/30/81</b>   |  | 2b. HOUR<br><b>8:54P</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Negro</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>25 1961</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ill.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TOWSON</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>  |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. STREET ADDRESS<br><b>3300 Tioga Parkway</b>   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George</b>   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Louise Wheatley</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>193-22-7512</b>  | 17. INFORMANT ADDRESS<br><b>Robert Harley 13700 Hanover Rd.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) CANCER OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 8, 1981</b> to <b>JAN 30, 1981</b> , that (I) (we) last saw the deceased alive on <b>JAN 30, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Annette B. Primm M.D.</b>   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/30/81</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR ANNELLE B PRIMM</b>   |   |   | 22e. ADDRESS<br><b>GBMC</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Cremation</b>  |   | 23b. DATE<br><b>2/5/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>   |
| 24. FUNERAL DIRECTOR NAME<br><b>W. C. Munch</b>  |   |   | ADDRESS<br><b>11012 North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1981</b>   |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |

113011 8:50P

PAUL LYNN FOR THE HARLEY

TOWSON

6701 W CHAMBER ST GENE

BALTIMORE

CAMDEN THE KING

JUN 30, 1961

DEC 1, 1961

JAN 30, 1962

GENIC

DR ANNELLE C PRINCE



JAMES 2 MARLINGER

MALE WHITE 11 19 41

BALTIMORE COUNTY

BALTO. ST. JOSEPH HOSPITAL

MARYLAND BALTIMORE BALTIMORE

BALTIMORE

BALTIMORE

CHARLES E. O'DONNELL MD

1941 4 1941

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100434  
REG. NO.

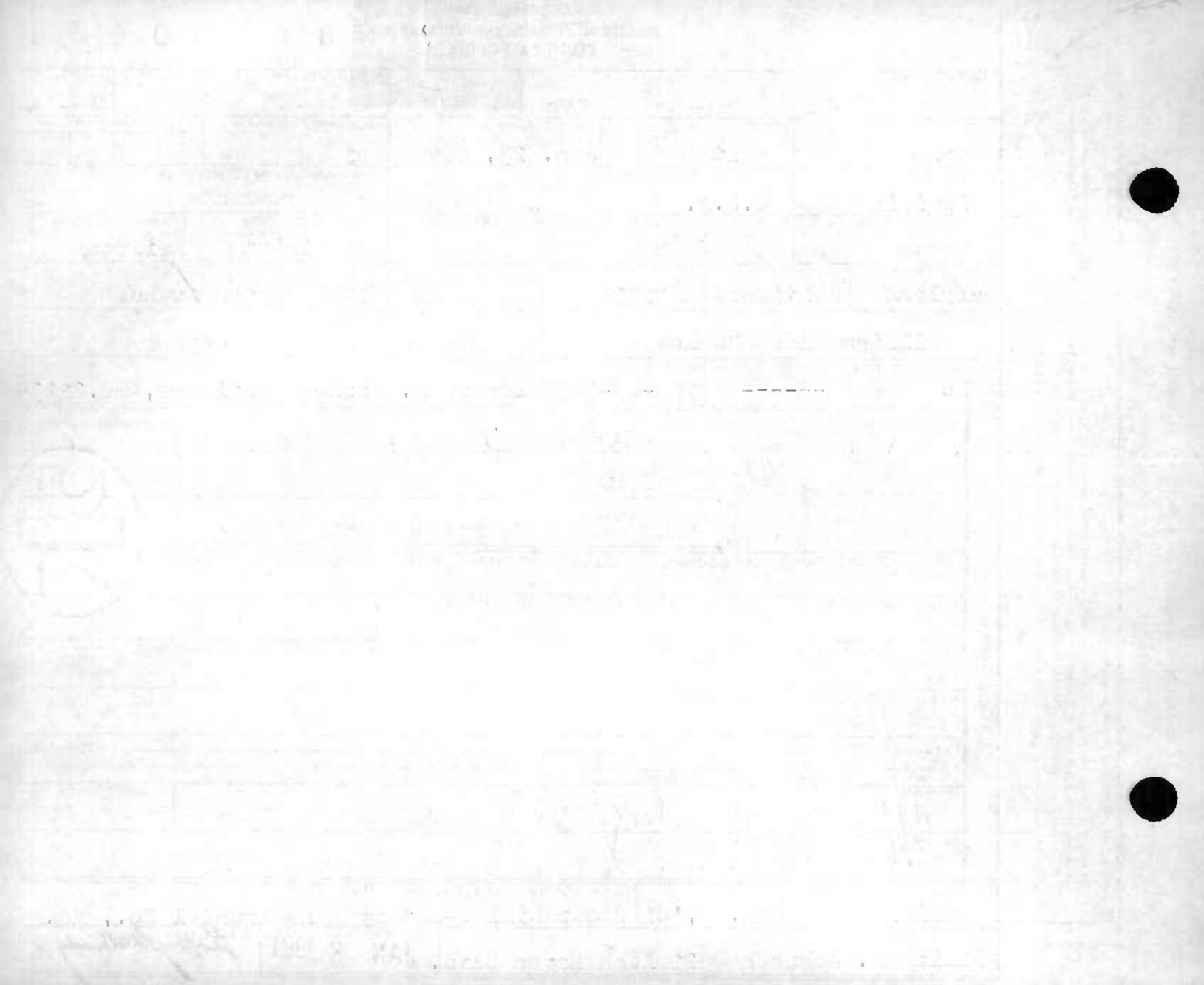
1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |                            |   |   |  |
|--|--|--|--|---|--|--|----------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph E. Harlow  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 5, 1981                    |   |  | 2b. HOUR<br>10:25a <sub>M</sub>  |                            |   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 23, 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |                            |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machinist        |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Railroad   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>21234 |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>William Flood Harlow  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>Rebecca Lee Keyser   |  |                            |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>705-05-3497                                |   | 17. INFORMANT ADDRESS<br>Edward D. Harlow Baltimore, Md. 21234   |  |                            |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Aspiration<br>5900 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } Uremia<br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause last. }<br>(b) }<br>(c) } DUE TO, OR AS A CONSEQUENCE OF<br>Acute and chronic pyelonephritis                          |  |  |  |   |  |  |                            |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |                            |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |                            |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                            |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 17, 1980, to Jan. 5, 1981, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on Jan. 5, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |                            |   |   |  |
| 22b. SIGNATURE<br>Maurice B. Furlong, M.D.   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                            | 22c. DATE SIGNED<br>Jan. 6, 1981  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Maurice B. Furlong, M.D.  |  |  |  |   | 22e. ADDRESS<br>7620 York Rd. Towson, Md. 21204  |  |                            |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Jan. 8, '81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., Md.   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson 8521 Loch Raven Blvd.   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1981  |  |                            | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 00435

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 1/29/81   |  | 8:10PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 17 1895   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>TOWSON MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6701 N CHARLES ST GBMC       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Wesley Harman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ada Parks  |  | 13e. STREET ADDRESS<br>Lutherville, Md.<br>1601 Division Avenue   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>216-32-4063   |  | 17. INFORMANT<br>ADDRESS<br>Ruth H. Whitelock, 1726 Kurtz Ave.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4289 IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARDIAC FAILURE</b>   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 7, 1981</u> , to <u>JAN 29, 1981</u> , that (I) (we) lost<br>saw the deceased alive on <u>JAN 29, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>P. Patel</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR P J PATEL  |  | 22e. ADDRESS<br>GBMC  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/2/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Grace U. Meth. Ch. Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Reisterstown, Md.   |  |
| 24. FUNERAL DIRECTOR<br><i>Martin D. Lawson</i>  |  | 25. ADDRESS<br>Lemmon-Mitchell-Wiedefeld  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |
| 24. FUNERAL DIRECTOR<br>Martin D. Lawson, 10 W. Padonia Rd.  |  |   |  |   |  |   |  |

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8100436   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>George H. Harris</b>  |  |   |  | 26. DATE OF DEATH MONTH <b>1</b> DAY <b>19</b> YEAR <b>81</b>   |  |   |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH MONTH <b>3</b> DAY <b>20</b> YEAR <b>94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CO</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE NURSING HOME</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GARDNER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>BALTO</b>  |  | 13c. CITY OR TOWN <b>MONKTON</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b>H.</b> LAST <b>HARRIS</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>ASHBY</b> LAST <b>ASHBY</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>219-10-3875A</b>  |  | 17. INFORMANT <b>Mrs. S. A. Hamilton</b>  |  | ADDRESS <b>3407 VANDER A CIRCLE RANDALLSTOWN, MD</b>  |  |   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for 10a, 1b, and 1c.)   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> 4 <sup>+</sup> YRS  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CONGESTIVE HEART FAILURE</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>5/5/76</b> to <b>1-19-81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Donald O. Wood MD</b> DEGREE  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>1/20/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald O. Wood</b>   |  |   |  | 22e. ADDRESS <b>TIMONIUM MD 21093</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>1/23/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. CO MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Chatman</b> ADDRESS <b>1/4 101 McCulloch St</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>John M. Kelly</b>   |  |

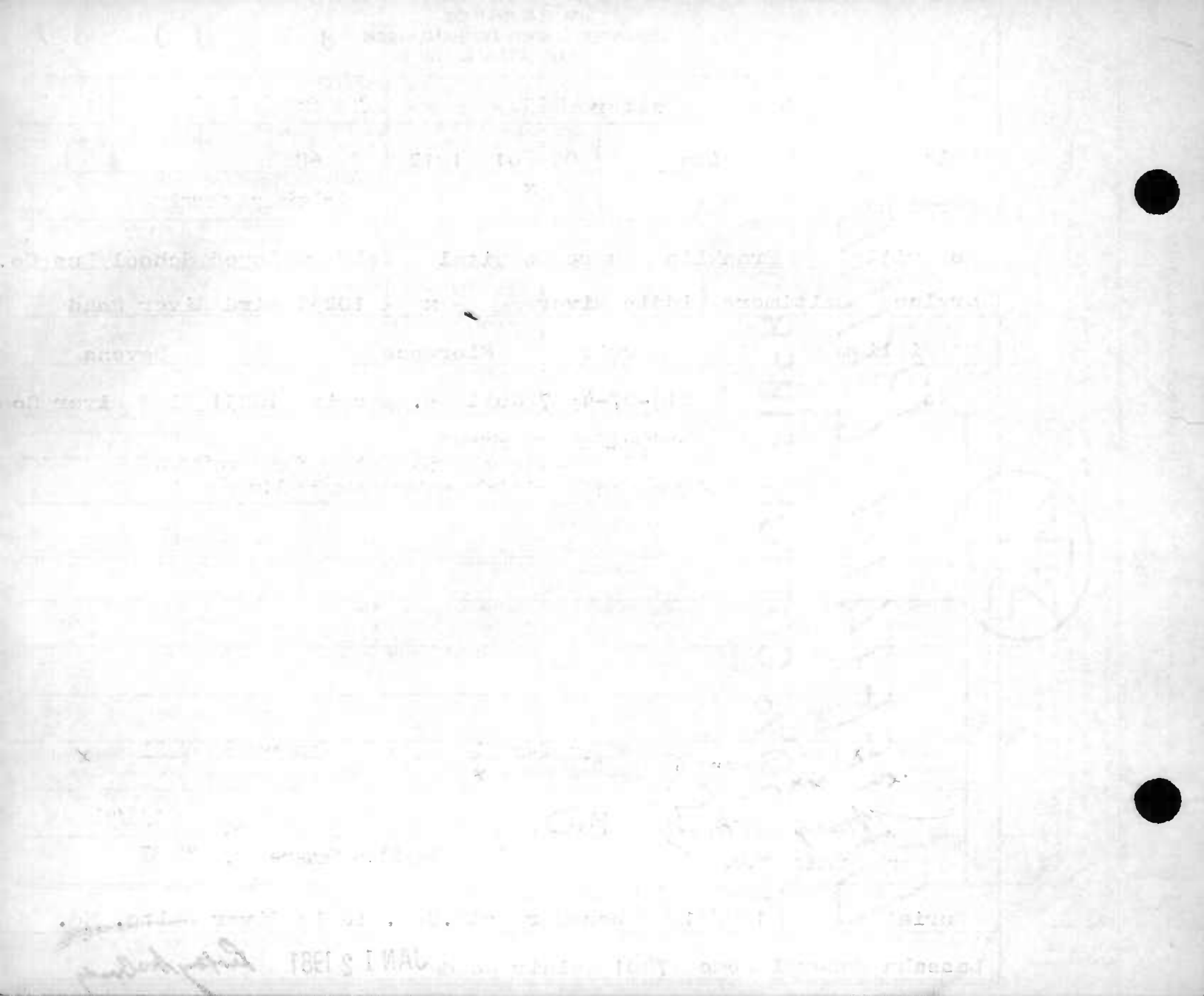


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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |  |                             |   | 8100437                                      |  |
|--|--|--|---|---|--|--|--|-----------------------------|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.  |   |  |  |  |                             |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |                             | 7b. HOUR  |  |  |
| John Walter HARRIS   |  |  |   |   |  | January 5, 1981  |  |                             | 9:50 P <sub>M</sub>   |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS |   | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male   |  | White  |   | 03 01 1912  |  | 68 YRS.  |  |                             |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                             |   |  |  |
| Maryland   |  | USA  |   |   |  | Baltimore County MD.   |  |                             |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Rossville  |  | Franklin Square Hospital   |   |   |  | Self employed  |  |                             | School Bus Co.  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13a. STATE  |   |  | 13b. CITY OR TOWN  |  |                             | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland   |  |  | Baltimore   |   |  | Middle River   |  |                             | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |   |  | 13c. STREET ADDRESS  |  |                             |   |  |  |
| William Harris   |  |  | Florence Bevens   |   |  | 10251 Bird River Road  |  |                             |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT ADDRESS  |  |                             |   |  |  |
| No   |  |  | 216-07-4557   |   |  | Julia M. Harris  |  |                             | 10251 Bird River Road   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br><u>1534</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Right hemicolectomy for carcinoma of cecum with multiple metastases to liver</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |   |   |  |  |  |                             |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |  |  |  |                             |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                             |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                             |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 21</u> , 19 <u>80</u> , to <u>January 5</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) saw the deceased alive on <u>January 5</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death. |  |  |   |   |  |  |  |                             |   |  |  |
| 27b. SIGNATURE   |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                             | 27c. DATE SIGNED  |  |  |
| <u>Mark Schutz</u>   |  |  | M.D.  |   |  |  |  |                             | 1/5/81  |  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 27e. ADDRESS  |   |  |  |  |                             |   |  |  |
| Mark Schutz, M.D.  |  |  | 9000 Franklin Square Dr., 21237                                     |   |  |  |  |                             |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |
| Burial   |  |  | 1/9/81  |   |  | Ebenezer Meth. Cem.  |  |                             | Middle River, Balt., Md.  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |                             | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Lassahn Funeral Home   |  |  |   |   |  | 7401 Belair Road   |  |                             | JAN 12 1981 <u>Richard A. Brady</u>   |  |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1

0 0 4 3 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SCOTT HARRIS  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 30 81 |  |  | 2b. HOUR<br>2:00 AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 9 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Balt. City Hosp. ta |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ref. Crane operator  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bldg Building   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balt.   |  | 13c. CITY OR TOWN<br>Balt.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Cicero Harris  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ila Franklin                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213-09-1290  |  |
| 17. INFORMANT<br>Drexel Harris   |  | 17. ADDRESS<br>110 Avondale Rd.  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic prostatic Ca</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>1850</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 months   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-21-</u> 19 <u>81</u> , to <u>1-30</u> 19 <u>81</u> that (I) (we) lost<br>saw the deceased alive on <u>1-29</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) not view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>R. Boutwell, M.D.  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED<br>1-30-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BOUTWELL  |  | 22e. ADDRESS   |  |  |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2-3-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balt. Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Carlton C. Douglas   |  | ADDRESS<br>103 Avondale Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>R. Boutwell  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1891 S 837

For [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1. STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 0 0 4 3 9<br>REG. NO.  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Carl Lee Harrison, Sr.</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/2/81</b>  |  |   |  | 2b. HOUR<br><b>500 A.M.</b>  |  |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 27, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS AM.<br><b>YRS.</b>  |  | 8. UNDER 24 HRS.<br>HOURS AM.<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>27 A Montrose Manor Apt.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>railroad</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>27A Montrose Manor Apt.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Harrison</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Olivia Peoples</b>  |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>                               |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>215 10 2102</b>  |  |  |  | 17. INFORMANT<br><b>27A Montrose Manor Apt.</b>   |  |   |  | 17. INFORMANT<br><b>Rita Harrison Catonsville, Maryland 21228</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>① Cerebral Hemorrhage</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>② Cerebral Infarction Hemiplegic</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>③ Myocardial Infarction</b><br><b>④ Myocardial Infarction</b><br><b>⑤ Generalized Arteriosclerosis</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>inst./2 years</b><br><b>1972</b><br><b>1957</b><br><b>1946</b>          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 80</b> , 19 <b>60</b> , to <b>1/2/81</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Nov 80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>W E McGrath MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/2/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W E McGrath MD</b>  |  |  |  | 22e. ADDRESS<br><b>1303 Frederick Rd Catonsville 21228 MD</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  |  |  | 23b. DATE<br><b>1/5/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Cem.</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City, Howard, Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SIACK Funeral Home, Ellicott City, Maryland 21043</b>  |  |  |  | ADDRESS<br><b>21043</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 5 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

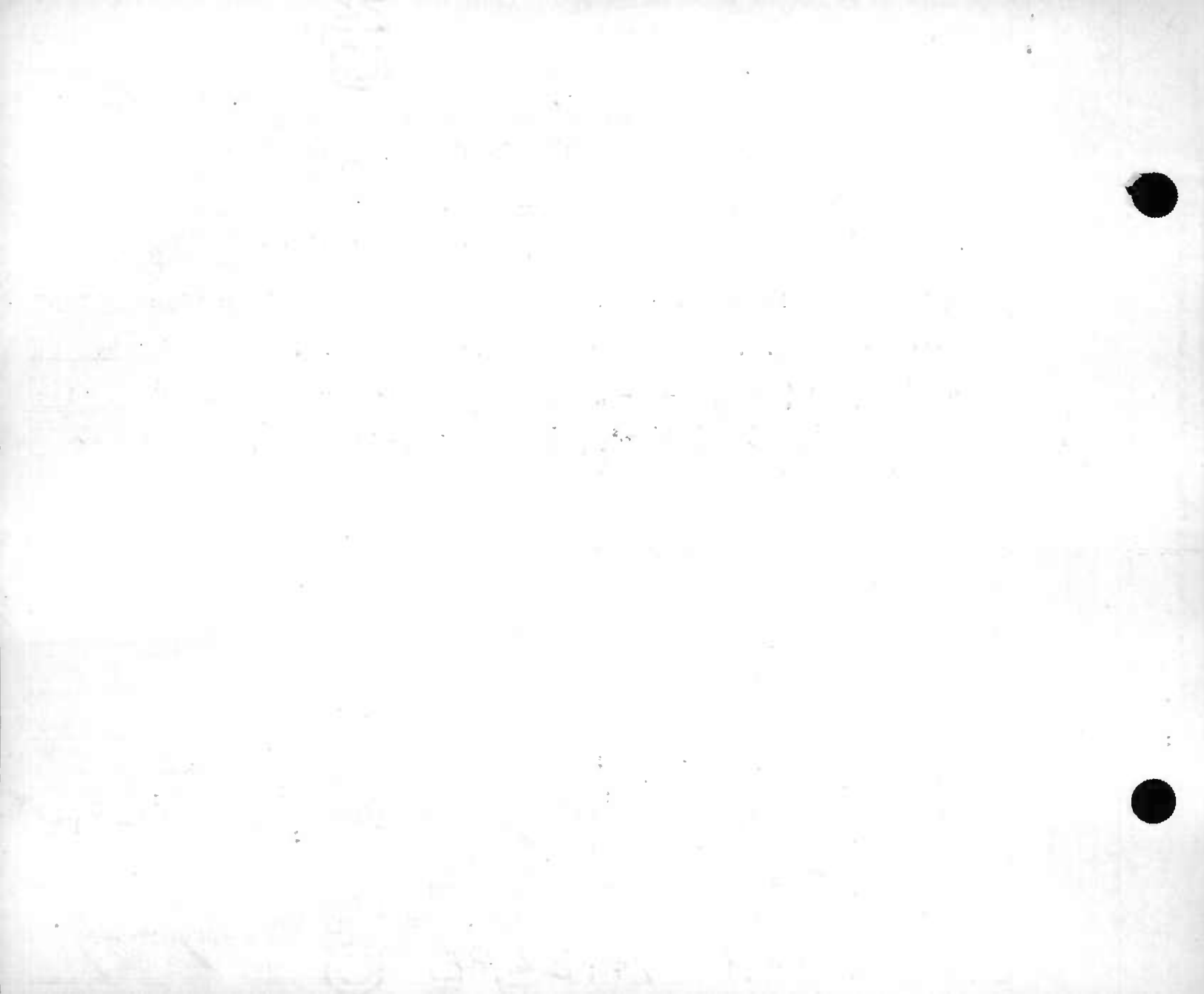
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8100440   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| FIRST MIDDLE LAST<br>Hazel Anna Harrison   |  |  |  | MONTH DAY YEAR<br>Jan. 13, 1981  |  |  |  | 9:10p M   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  |
| Female   |  | White  |  | MONTH DAY YEAR<br>11/13/1894   |  | 86 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| West Virginia  |  | USA  |  |  |  | Baltimore County MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Towson   |  | St. Joseph Hospital  |  |  |  |  |  | Housewife   |  | Homemaking   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Maryland   |  |  |  | Baltimore  |  | Rosedale   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 9208 Swiven Place 21237  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |
| FIRST MIDDLE LAST<br>Waitman T.W. Wheeler  |  |  |  | FIRST MIDDLE LAST<br>Mary M.C. Smalley   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| No   |  |  |  | 224-50-7736  |  | Eleanor Greentree 9208 Swiven Place  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 CONGESTIVE HEART FAILURE  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 DAYS         |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
|  |  |  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from Jan. 10, 1981, to Jan. 13, 1981, that (we) last saw the deceased alive on Jan. 13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (how) (did) (do you) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| James Kleeman  |  |  |  | MD   |  |  |  | 1.14.81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| James Kleeman, M.D.  |  |  |  | 7600 Osler Drive, Towson, Md. 21204  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Burial   |  |  |  | 1/17/81  |  | Parklawn Mem. Park   |  | Hampton Va.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE RECORDED BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Lessa Funeral Home   |  |  |  | 7901 Belknap Rd  |  |  |  | JAN 19 1981   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M 2/80

| FOR<br>1- STATE REGISTRAR  |  |                                 |  |  |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH     |  |  |  |  |  |  |  |  |  | REG. NO. 00441 |  |
|--|--|---------------------------------|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Phyllis Bertha Harrison</b>   |  |                                 |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH  |  | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  | 2b. HOUR                                     |  |  |  |  |  |                |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>         |  | 5. DATE OF BIRTH<br>MONTH <b>May</b> DAY <b>22</b> YEAR <b>1930</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>50</b> YRS.   |  | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>       |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>1</b> DAY <b>19</b> YEAR <b>81</b>                              |  | 2d. HOUR<br><b>2:57</b> P M                  |  |  |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                   |  |  |  |  |  |  |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8113 Dundalk Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerical-Shipbuilding</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |                |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b> |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8113 Dundalk Avenue</b>   |  |  |  | 21222  |  |  |  |  |  |  |  |                |  |
| 14. FATHER'S NAME<br>FIRST <b>Frederick</b> MIDDLE <b>W.</b> LAST <b>Schneider, Sr.</b>  |  |                                 |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lena</b> MIDDLE <b></b> LAST <b>Tanke</b>         |  |  |  |  |  |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, A17, OR UNKNOWN) <b>NO</b>   |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-0504</b>   |  |   |  | 17. INFORMANT<br><b>Mr. William J. H. Harrison</b>  |  |  |  | ADDRESS<br><b>8113 Dundalk Avenue</b>  |  |  |  |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Amitriptyline Intoxication</b><br><b>9503</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>(c) <b></b>  |  |                                 |  |  |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                 |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 19a. DATE OF OPERATION   |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |  |  |  |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 1/19/ 1981</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject ingested drugs</b>  |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  |   |  | 21f. LOCATION<br>STREET <b>8113 Dundalk Ave.</b> CITY OR TOWN <b>Dundalk, Balto. Co.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>                                 |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                 |  |  |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |                |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                                 |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>1/20/81</b>   |  |  |  |  |  |  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                                 |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                                 |  | 23b. DATE <b>1/22/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>                                |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Md.</b> |  |  |  |  |  |  |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mc Cutty Funeral Home of Brooklyn</b><br>ADDRESS <b>237 E. Patapsco Avenue Baltimore, Md. 21225</b>  |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1981</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Rafael McBrady</b>  |  |  |  |  |  |  |  |  |  |  |  |                |  |



SECTION 1000



1000



1000

Handwritten signature or mark at the bottom left corner.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| Item 1 g555 5/28/81 gj   |  | STATE OF MARYLAND   |  | 8100442  |  |
| 1. FOR<br>STATE<br>REGISTRAR   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| Kathleene Rose HARTMAN   |  |   |  | January 31, 1981   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| Female   |  | White   |  | January 31, 1981   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Maryland   |  | U.S.  |  | YRS. MONTHS DAYS   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Balto., County   |  | Franklin Square Hospital  |  | Baltimore County MD.   |  |
| 12a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. STREET ADDRESS  |  |
| Maryland   |  | Baltimore   |  | 3701 Old North Point Road. TR. 42  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |
| Richard Joseph Hartman   |  | Elizabeth Ann Bradds  |  | No   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |
|  |  | Father-3701 Old North Point Rd. TR. 42  |  | PART 1. DEATH WAS CAUSED BY:   |  |
|  |  |   |  | IMMEDIATE CAUSE (a) Severe Prematurity   |  |
|  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Collapse   |  |
|  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |
|  |  |   |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |
|  |  |   |  | P.M. 19  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (we) attended the deceased from January 31, 1981, to January 31, 1981, that (I) (we) lost the deceased alive on January 31, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE DEGREE   |  | 22c. DATE SIGNED   |  |
| Margaret A. Mulligan   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 1/31/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |
| Margaret A. Mulligan, M.D.   |  | 9000 Franklin Square Dr., Balto., Md 21237  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
|  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Franklin Sq. Hospital  |  | FEB 6 1981  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |  |  | REG. NO. 81 00443   |  |
|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES L. HARTMAN</b>   |   | 2a. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>1981</b>   |  | 2b. TIME OF DEATH <b>6:00 PM</b>  |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>White</b>  | 5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>11</b> YEAR <b>1923</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.                   | IF UNDER 1 YEAR MONTHS <b>57</b> DAYS <b>57</b> HOURS <b>57</b> MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A. USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME, BROTH, OR INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Typist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>  |  |
| 13a. STATE <b>Maryland</b>   |   |  | 13b. CITY OR TOWN <b>Baltimore</b>                               | 13c. STREET ADDRESS <b>623 N. Clinton St., 21205</b>                              |  |
| 14. FATHER'S NAME FIRST <b>Adam</b> MIDDLE <b>-</b> LAST <b>Slawski</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Agnes</b> MIDDLE <b>-</b> LAST <b>Lukowski</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |   | 16b. SOCIAL SECURITY NO. <b>218-18-7013</b>  |  | 17. INFORMANT ADDRESS <b>same address</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |   |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe liver failure</b>   |   |  |  |   |  |
| 1539   |   |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic liver failure</b>  |   |  |  |   |  |
| (c) <b>Co of Colon</b>   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>12/21/80</b> , 19 <b>81</b> , to <b>1/4</b> , 19 <b>81</b> , that (we) lost saw the deceased alive on <b>1/4</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (and) (may) view the body after death. |   |  |  |   |  |
| 22b. SIGNATURE <b>Max R. Penz</b>  |   | DEGREE   |  | 22c. DATE SIGNED <b>01/04/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Max R. Penz M.D.</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22e. ADDRESS <b>7620 YORK RD TOWSON MD 21204</b>                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |   | 23b. DATE <b>1/8/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>                    |  |
| 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b>  |   | 23e. NAME OF FUNERAL DIRECTOR <b>Schamunek Funeral Home, Inc.</b>  |  | 23f. ADDRESS <b>3331 Brehms Lane Balto., Md. 21213</b>                            |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Schamunek Funeral Home, Inc.</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Robert H. H. H.</b>                                 |  |

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CHICAGO, ILL.

8

*[Faint, mostly illegible handwritten notes and text, possibly bleed-through from the reverse side of the page.]*

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |   |  |  |  |                                     |  |
|--|--|---|--|---|--|---|--|--|--|---|--|--|--|-------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 8   |  | 1   |  | 0   |  | 0  |  | 4   |  | 4  |  | 4                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SOPHIE SOPHIE HARTMAN HARTMAN</b>   |  |   |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>4</b> YEAR <b>1981</b>                               |  |  |  | 2b. TIME OF DEATH<br><b>1:50 P.</b> |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>JULY 15, 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73 years</b>                        |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>XXX</b> DAYS <b>XXX</b>  |  | 8. IF UNDER 24 HRS<br>HOURS <b>XXX</b> MIN <b>XXX</b>   |  |  |  |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>           |  |  |  |   |  | MD.  |  |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b> |  |   |  |   |  | 12a. USABLE EMPLOYED<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DRESSMAKER</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>  |  |  |  |                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |   |  |   |  |   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>APT. 103 6628 VINCENT LA. #21215</b> |  |                                     |  |
| 14. FATHER'S NAME<br>FIRST <b>SEYMOUR</b> MIDDLE <b>GERTZ</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>GOLDIE</b> MIDDLE <b>REVEN</b>   |  |   |  |  |  |   |  |  |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO<br><b>266-38-4519</b>   |  | 17. INFORMANT<br><b>HEBREW BURIAL &amp; SOCIAL SER. SOC. ADDRESS 1330 REISTERSTOWN RD. BALTO., MD 21208</b>   |  |   |  |  |  |   |  |  |  |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive shock</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute renal failure</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Acute renal failure</b>  |  |   |  |   |  |   |  |  |  |   |  |  |  |                                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |  |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |                                     |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |   |  |  |  |                                     |  |
| 22a. SIGNATURE<br><b>Hafeez A Syed</b>   |  |   |  | DEGREE  |  |   |  | 22b. DATE SIGNED<br><b>1/4/81</b>  |  |   |  |  |  |                                     |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEZ A SYED M.D.</b>   |  |   |  | 22d. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSP.</b>  |  |   |  |  |  |   |  |  |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>JAN. 6, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |  |  |   |  |  |  |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL. LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1981</b>                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |  |  |                                     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 81 00445  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | MARIE E. HARTZELL                                       |  |  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  |
|  |  |   |  |  |  | 1 28 '81  |  | 2b. HOUR   |  |
|  |  |   |  |  |  |   |  | 11:40P   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  |
| FEMALE   |  | WHITE   |  | March 18, 1908   |  | 72 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Maryland   |  | USA   |  |  |  | BALT IMORE COUNTY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| TOWSON   |  | GBMC-6701 N. CHARLES ST.                                |  |  |  | Homemaker   |  | Own Home   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Maryland   |  |   |  | Balto.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 823 Evesham Avenue   |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |
| FIRST MIDDLE LAST  |  |   |  | FIRST MIDDLE LAST  |  |   |  |  |  |
| Edward Anthony Hunhold   |  |   |  | Alice E. Bull  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |
| No   |  |   |  | 213 30 7916  |  | Mrs. Benjamin West, Balto., Md.                                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST   |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF BREAST   |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR                                |  |  |  |   |  |  |  |
|  |  | P.M.  |  | 19   |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET   |  | CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-24, 19 81, to 1-28, 19 81, that (I) (we) last saw the deceased alive on 1-28, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE  |  |  |  | 22c. DATE SIGNED  |  |  |  |
| Michael B. Grieco MD   |  |   |  |  |  | 1-28-81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |   |  |  |  |
| MICHAEL B. GRIECO, M.D.  |  | GBMC-6701 N. CHARLES ST.                                |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | STATE  |  |
| Burial   |  | 1/31/81   |  | Parkwood Cemetery  |  | Balto. County,  |  | Md.  |  |
| 24. FUNERAL DIRECTOR   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. RECEIVED BY SIGNATURE                                     |  |
| Henry W. Jenkins & Sons Co.  |  |   |  |  |  | FEB 2 1981  |  | [Signature]  |  |
| 4905 York Road Balto., Md. 21212   |  |   |  |  |  |   |  |  |  |



Burial 1/21/81  
Henry W. Jenkins & Sons Co.  
4608 York Road Balto., Md. 21212  
Parkwood Cemetery Balto. County, Md.

MICHAEL J. G. 1920-1981

1-23-81

1-23-81

x

No 219 30 7618 Mrs. Benjamin West, Balto., Md.

Edward Anthony Hunnold Alice E. Full  
Maryland N. Balto. x 623 Evesham Avenue

01204 6202-2501 W. Charles St. Homemaker  
Maryland USA x BALTIMORE COUNTY  
March 18, 1908

WASTELL 7 15 1 28 11:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8100446  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Teresa H. Havran   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 10 81  |  |  |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 2 1888   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Czechoslovakia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Czechoslovakia  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Randallstown Convalescent Cr. |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Florian Pausch   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Not Known  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO<br>215-76-8535  |  | 17. INFORMANT<br>Frederick M. Havran   |  | ADDRESS 7431 School Ave. Balto. MD 21222   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Pericardial artery dissection</u><br>4/49<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ascv</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>78</u> to <u>11/10</u> , 19 <u>81</u> , that (I) (we) lost <u>11/6</u> <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br>Daniel Wilfson  |  |   |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>11/12/81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel Wilfson, M.D.   |  |   |  | 22e. ADDRESS<br>3502 W. Rogers Ave., Baltimore, MD 21215   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/13/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |   |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.  |  |   |  | ADDRESS<br>7922 Wise Avenue, Dundalk, MD 21222   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1981   |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |   |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 00447

REG. NO.

8

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |   |   |  |   |  |
|--|--|--|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE W. HAYWOOD</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-26-81</b>                         |   | 2b. HOUR<br><b>5:10A<sub>M</sub></b>                     |   |   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 31 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lithographer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CT-C+SGA1</b>  |   |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Parkville</b>                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2916 Kings Ridge Rd</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John B Haywood</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Froehlich</b>   |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-01-2479</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Hosp. Records</b>         |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CANCER OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-20</b> , 19 <b>81</b> , to <b>1-26</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1-26</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>M. Gonzales</b>   |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/26/81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANUEL GONZALES, M.D.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>1-28-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Lm</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Co MD</b>                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS Funeral Chapel 8800 Harford Rd</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

ADT: 1.

18-2-1

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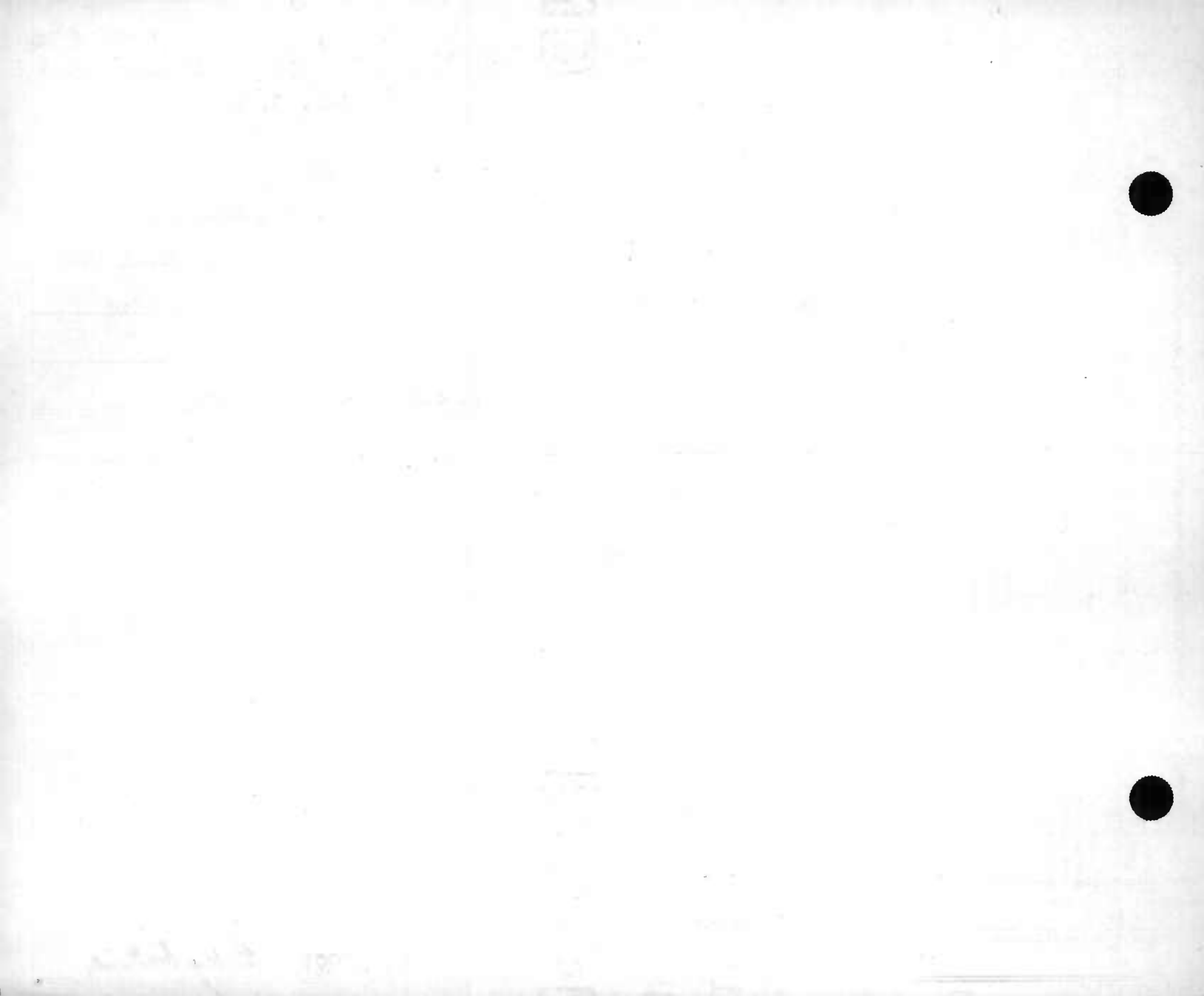
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |   |  |   | 8100443  |  |
|---|--|---|--|--|---|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   | REG. NO.   |  |   |   |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Leona A. Haywood</b>   |  |   | 2a. DATE OF DEATH<br><b>Jan. 3, 1981</b>                               |  |   | 2b. HOUR<br><b>M</b>  |   |  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>April 18, 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2916 Kings Ridge Road</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dress Shop</b>   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>PARKVILLE</b>                 |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2916 Kings Ridge Road</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Herman</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Tropperman</b>  |   |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219 03 7560</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>XXXXXX Family records</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>1911<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Astrocytoma of brain (frontal lobe)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Duration 6 months</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11</b> , 19 <b>80</b> , to <b>12-3-81</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased <b>alive</b> on <b>19</b> above, (I) (we) did <b>not</b> view the body after death.   |  |   |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>A. Shafik</i>  |  |   |  |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1-7-81</b>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. Sateh Shafik M.D.</b>  |  |   |  |  |   | 22e. ADDRESS<br><b>7800 York Road</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  |   | 23b. DATE<br><b>1/7/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. County</b>                              |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Evans Funeral Chapel 8800 Harford Road</b>   |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Ruby Roberts</i>  |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8100449                                      |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR                                     |  |
| ELIZABETH  |  |  |  |   |  | HAZARD  |  | JANUARY 9, 1981  |  | 6:00 A.M.                                    |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  | IF UNDER 24 HRS HOURS MIN                    |  |
| F  |  | W  |  | April 17, 1880  |  | 100 YRS.  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |  |  |
| Baltimore, Md.   |  | USA  |  |   |  | BALTIMORE COUNTY MD.  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| TOWSON   |  | Dulaney Towson Nursing Center  |  |   |  |   |  | Homemaker  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| Md.  |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | Marble Hall Road   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |  |  |  |  |
| William Eidman   |  |  |  |   |  | Catherine Sauers  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS  |  |  |  |  |  |
| no   |  |  |  | 220 44 4299   |  | Mrs. Margaret Hughes 108 Dunkirk Road                               |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) 4140 V. Extensive Sclerotic Heart Disease  |  |  |  |   |  |   |  |  |  | 15 yrs                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Diverticulitis  |  |  |  |   |  |   |  |  |  | 20 yrs                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arterio Sclerosis   |  |  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)  |  |  |  |   |  |   |  |  |  |  |  |
| Arrested Pulmonary T.B. 8 months   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| none   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
|  |  | P.M. 19  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
|  |  |  |  |   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10/45, 19 to July 9, 1981, that (I) (we) last saw the deceased alive on Dec. 18, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |   |  | 22c. DATE SIGNED   |  |  |  |
| Earl L. Chambers   |  | MD   |  |   |  |   |  | 1/9/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |   |  |  |  |  |  |
| Earl L. Chambers   |  |  |  | 100 W. Cold Spring  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| Burial   |  | 1/12/81  |  | Loudon Park Cem.  |  | Baltimore, Md.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | ADDRESS   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR                                |  | 25b. REGISTRAR'S SIGNATURE                   |  |
| MITCHELL-WIEDEFELD HOME  |  |  |  | 6500 York Rd.   |  |   |  | JAN 14 1981  |  |  |  |

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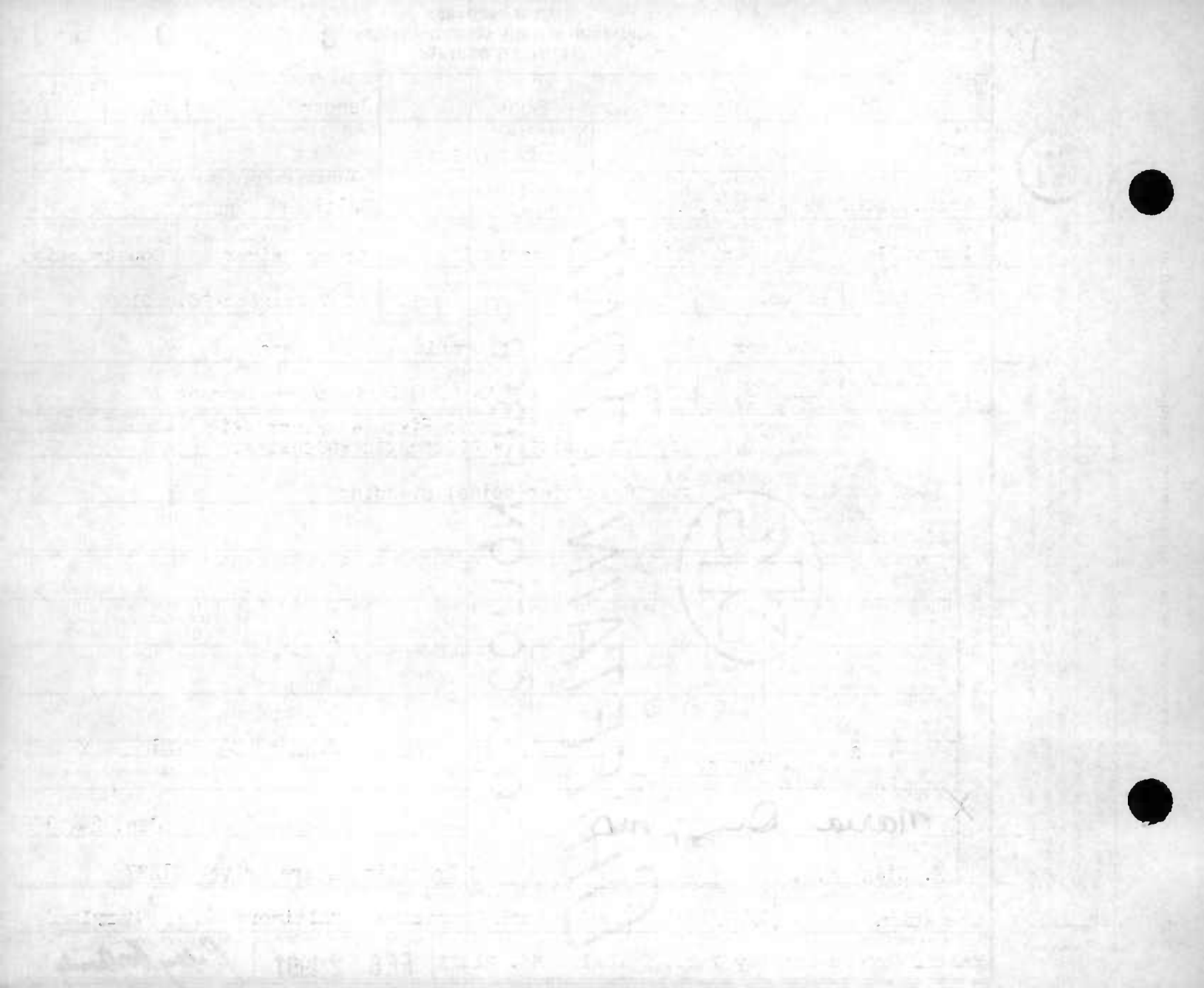
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called or called at 1-800-368-5711.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8100450 |  |
|---|--|--|--|---|--|---|--|--|--|---------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |  |  |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ralph Chester HAZARD</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 24 1981</b>                                   |  | 2b. HOUR<br><b>10:00 PM</b>  |  |         |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 13, 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |         |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |  |         |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1707 Searles Rd. 21222</b>   |  |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hugh Chester Hazard</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eugenia Mae Howe</b>  |  |   |  |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | (IF YES, GIVE WAR OR DATES)<br>-----   |  | 16b. SOCIAL SECURITY NO.<br><b>579.07.5640</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ruth V. Whittington---Same as 13e</b>                            |  |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cyst with multiple pancreatic abscesses.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Upper Gastrointestinal Bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |         |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>November 12, 1980</b> , to <b>January 24, 1981</b> , that (I) (we) lost saw the deceased alive on <b>January 24, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (not) view the body after death.   |  |  |  |   |  |   |  |  |  |         |  |
| 22b. SIGNATURE<br><b>Maria Diaz, MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED<br><b>Jan. 24, 1981</b>   |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. Diaz M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |  |   |  |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1/27/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc., Dundalk, Md. 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. H. H. H.</b>  |  |  |  |         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 81 00451  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>EDITH M. HEAGY   |  |  |  | January 7, 1981  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb 7 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Clark   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sophia Stein   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>216-03-3318  |  | 17. INFORMANT ADDRESS<br>Mrs. Celina H. Matthews 7507 Stone Cutter Ct.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest due to probable<br>4100 Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) }<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) }<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 12/2, 1980, to 1/7, 1981, that (we) lost saw the deceased alive on 1/2, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>N. Haroun  |  |  |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/7/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Haroun  |  |  |  | 22e. ADDRESS<br>9101 Franklin Square Drive 21237   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 10, 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |
| Ruck Funeral Home 5305 Maryland Rd.  |  |  |  |  |  |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. IF THE DEATH OCCURS AT DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |  |                                |   |  |   |  | REG. NO. 00452   |  |               |
|--|------------------|--|--|--|--------------------------------|---|--|---|--|--|--|---------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Melvin L. Heer   |                  |  |  |  |                                |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 23 1981      |  | 2b. HOUR<br>M |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH MONTH DAY YEAR<br>Mar. 11, 1910   | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS.<br>70 | 7. IF UNDER 1 YR. MONTHS DAYS  | 8. IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>1 23 1981   |  | 2d. HOUR<br>1:30 a M  |  |  |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                 |  |   |  |  |  |               |
| 10. CITY OR TOWN OF DEATH<br>Towson  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |  |  |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Pharmacist   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |               |
| 13a. STATE<br>Maryland   |                  |  |  |  |                                |   |  |   |  | 13b. COUNTY<br>Baltimore   |  |               |
| 13c. CITY OR TOWN<br>Towson  |                  |  |  |  |                                |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |               |
| 13e. STREET ADDRESS<br>805 Starbit Court   |                  |  |  |  |                                |   |  |   |  |  |  |               |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William J. Heer   |                  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>May E. Lentz   |                                |   |  |   |  |  |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |                  |  |  | 16b. SOCIAL SECURITY NO.<br>215-30-2061  |                                | 17. INFORMANT ADDRESS<br>Elsie F. Heer, Same As #13e                          |  |   |  |  |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute myocardial infarct<br>4100<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                  |  |  |  |                                |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |               |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |               |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |               |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |  |  |               |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |                  |  |  |  |                                |   |  |   |  |  |  |               |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.  |                  |  |  | TITLE (SPECIFY)<br>Deputy Chief  |                                |   |  | MEDICAL EXAMINER<br>DATE SIGNED 1/23/81   |  |  |  |               |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |                  |  |  | ADDRESS<br>111 Penn ST. Balto., MD.  |                                |   |  |   |  |  |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>1-26-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Cem.   |                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Parkville, Balto. Maryland         |  |   |  |  |  |               |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |                  |  |  | ADDRESS<br>1050 York Rd.   |                                | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1981                                  |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy                                      |  |  |  |               |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8100453            |     |  |                     |                                   |  |
|--|--|---|--|---|--|---|--|--|--|--------------------|-----|--|---------------------|-----------------------------------|--|
| FOR<br>1. REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH              | DAY | YEAR   | 2b. HOUR            |                                   |  |
| GERTRUDE   |  | HELLMAN   |  |   |  |   |  | 1-13-81  |  |                    |     |  | 12 <sup>30</sup> PM |                                   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  | 8. IF UNDER 24 HRS |     |  |                     |                                   |  |
| FEMALE   |  | CAUCASIAN   |  | 9-15-86   |  | 94 YRS.   |  | MONTHS   |  | DAYS               |     | HOURS MIN.   |                     |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                    |     |  |                     |                                   |  |
| LITHUANIA  |  | U.S.A.  |  |   |  | BALTIMORE COUNTY MD   |  |  |  |                    |     |  |                     |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |  |  |                    |     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                     | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| RANDALLSTOWN   |  | BALTIMORE COUNTY GENERAL HOSPITAL   |  |   |  |   |  |  |  |                    |     | HOUSEWIFE  |                     | AT HOME                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                    |     |  |                     |                                   |  |
| MARYLAND   |  | BALTIMORE   |  | BALTIMORE   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2429 SYLVALE RD. #21209  |  |                    |     |  |                     |                                   |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |                    |     |  |                     |                                   |  |
| DAVID  |  |   |  | ROSE  |  |   |  | YESELOLOVEVITZ   |  |                    |     |  |                     |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT ADDRESS  |  |                    |     |  |                     |                                   |  |
| NO   |  |   |  | 219-32-0519D  |  |   |  | MRS. EVA BERKOW<br>2429 SYLVALE RD. #21209                     |  |                    |     |  |                     |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |  |  |  |                    |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |                     |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                    |     |  |                     |                                   |  |
| NA   |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                    |     |  |                     |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-8-81 to 1-13-81, that (I) (we) lost<br>saw the deceased alive on 1-13-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |   |  |  |  |                    |     |  |                     |                                   |  |
| LONDYAL V. REDDY   |  | MD  |  | 1-13-81   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| LONDYAL V. REDDY   |  | BALTO. COUNTY GEN. HOSPITAL<br>RANDALLSTOWN, MD, 21133  |  |   |  |   |  |  |  |                    |     |  |                     |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |                    |     |  |                     |                                   |  |
| BURIAL   |  | 1-14-81   |  | POSVOHLER FRIENDLY SOC.   |  |   |  | BALTIMORE MD   |  |                    |     |  |                     |                                   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. DATE REC'D. BY REGISTRAR   |  |   |  | 24c. REGISTRAR'S SIGNATURE  |  |  |  |                    |     |  |                     |                                   |  |
| SOL LEVINSON & BROS., INC.   |  | 21215   |  |   |  | JAN 21 1981   |  | [Signature]  |  |                    |     |  |                     |                                   |  |
| 6010 REISTERSTOWN RD., BALTO., MD  |  |   |  |   |  |   |  |  |  |                    |     |  |                     |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8100454<br>REG. NO.  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CAROLINE W. HELLWIG<br>Carrie  |  |  |  | January 4 1981   |  |   |  | 8:05 pm   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>May 28, 1892   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>88   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                       |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Edward Bauer  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Carrie W. Reuther  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-05-6399  |  | 17. INFORMANT ADDRESS<br>Emma W. Baker 106 Greenridge Court                       |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Disease</u><br><u>4273</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Dehydration, Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atrial fibrillation</u>     |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 3, 1981, to January 4, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 4, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br>1/4/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Masvidal  |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-8-1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                     |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc. Towson, Maryland  |  |  |  | ADDRESS<br>1050 York Road  |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 7 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |



1/4/12

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                              |   |   |      |  |  |  |                                   |  |          |
|---|--|------------------------------|---|---|------|--|--|--|-----------------------------------|--|----------|
| 1. FOR STATE REGISTRAR  |  | 8 1 0 0 4 5 5                |   | REG. NO.  |      |  |  |  |                                   |  |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST   | MIDDLE  | LAST | 2a. DATE OF DEATH  |  | MONTH  | DAY                               | YEAR   | 2b. HOUR |
| Irene   |  |                              | A.  |   | Helm | January  |  | 28,  | 1981                              | 12:15A   | M        |
| 3. SEX  |  | 4. RACE                      |   | 5. DATE OF BIRTH  |      | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS  |          |
| female  |  | white                        |   | MONTH DAY YEAR<br>9/18/90   |      | 90   |  | MONTHS DAYS  |                                   | HOURS MIN.   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                                   |  |          |
| PA  |  | USA                          |   |   |      | Baltimore County MD.   |  |  |                                   |  |          |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |
| Randallstown  |  |                              | Randallstown Convalescent Center  |   |      | Receptionist   |  |  | Doctor's office                   |  |          |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |   |   |      |  |  |  |                                   |  |          |
| 13a. STATE  |  | 13b. COUNTY                  |   | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                                      |                                   |  |          |
| MD  |  | Baltimore                    |   | Timonium  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | Melanchton Ave. 21093                                    |                                   |  |          |
| 14. FATHER'S NAME   |  |                              |   | 15. MOTHER'S MAIDEN NAME  |      |  |  |  |                                   |  |          |
| FIRST MIDDLE LAST   |  |                              |   | FIRST MIDDLE LAST   |      |  |  |  |                                   |  |          |
| Patrick   |  |                              |   | Mary Carr   |      |  |  |  |                                   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |                              |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |      | 17. INFORMANT ADDRESS  |  |  |                                   |  |          |
| No  |  |                              |   | -   |      | Mrs. Mary R. Endsley<br>1306 Woodland Circle, New Windsor, MD 21226            |  |  |                                   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                              |   |   |      |  |  |  |                                   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |   |   |      |  |  |  |                                   |  |          |
| 19a. DATE OF OPERATION  |  |                              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |      |  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |
|   |  |                              |   |   |      |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                              |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                                   |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10/81 to 1/28/81, that (I) (we) lost saw the deceased alive on 11/10/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                              |   |   |      |  |  |  |                                   |  |          |
| 22b. SIGNATURE  |  |                              |   | DEGREE  |      |  |  | 22c. DATE SIGNED   |                                   |  |          |
| Dr. Daniel Wilfson  |  |                              |   |   |      |  |  | 1/28/81  |                                   |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              |   | 22e. ADDRESS  |      |  |  |  |                                   |  |          |
| Dr. Daniel Wilfson  |  |                              |   | 3502 W Rogers Ave. Baltimore, MD 21215  |      |  |  |  |                                   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              |   | 23b. DATE   |      | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |                                   |  |          |
| Cremation   |  |                              |   | 1/30/81   |      | Loudon Crematory   |  | Baltimore City MD  |                                   |  |          |
| 24. FUNERAL DIRECTOR NAME   |  |                              |   | 25a. DATE REC'D. BY REGISTRAR   |      |  |  | 25b. REGISTRAR'S SIGNATURE                               |                                   |  |          |
| Loring Byers Funeral Directors P.A.<br>8728 Liberty Rd. Randallstown, Maryland 21133  |  |                              |   | JAN 30 1981   |      |  |  |  |                                   |  |          |



CHIEF OF BUREAU

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 81 00456  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>BEULAH Carola HENORIX</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1-30-81</b>  |  |   |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12 26-00</b>  |  | 2b. HOUR <b>9:45</b> M.   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO. Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley Hosp + Conv. Center</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>County, Baltimore</b> MD.  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>--</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Hartman</b> LAST <b>Hartman</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Kohlman</b> LAST <b>Kohlman</b>   |  | 13e. STREET ADDRESS <b>3939 Roland Ave. (21211)</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>172-01-2609</b>  |  | 17. INFORMANT <b>Thelma Righter-5841 Dewey St, Cheverly, Md.</b>   |  | ADDRESS <b>20785</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____        |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 13</b> , 19 <b>81</b> , to <b>JAN 30</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>JAN 30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Stephen K. Dyal</b>  |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>1/31/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN K. DYAL</b>   |  | 22e. ADDRESS <b>8501 LASALLE RD TOWSON 21204</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>1/31/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Security Process, Inc.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz Funeral Home</b> ADDRESS <b>3818 Roland Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Isis...</b>   |  |

No

175-01-2009

Thomas Ripper-Gill Dewey St, Chevy Chase, Md.

Charles

Hartman

Harry

Kathleen

Maryland

--

Baltimore

XX

2339 Roland Ave. (S111)

House 111

Townson

Baltimore

with

Carole

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8100457  
REG. NO.

|  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>William K. HENSLEY  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 18, 1981  |  | 7b. HOUR<br>10:20 P.M.   |  |
| 3. SEX<br>Male   |  | 4 RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 10, 1920   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>60<br>YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Labor   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Cemetery  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Essex   |  | 13c. STREET ADDRESS<br>4 Wilbur Road 21221  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samson - Hensley   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella - Parker   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17 INFORMANT<br>ADDRESS<br>Tempie Hensley, wife Same   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest, Carcinoma Metastatic</u><br><u>4275</u> DUE TO, OR AS A CONSEQUENCE OF<br>with Neurosis, Dehydration<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>January 16, 1981</u> to <u>January 18, 1981</u> , that (we) lost <u>the deceased alive on January 18, 1981</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) (see) (the body after death).  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Pedro Pina</u><br>PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/18/81  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  |   |  | 23b. DATE<br>1-21-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holcombe Brothers Funeral Home, Burnsville, N.C.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave   |  |   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Pedro Pina</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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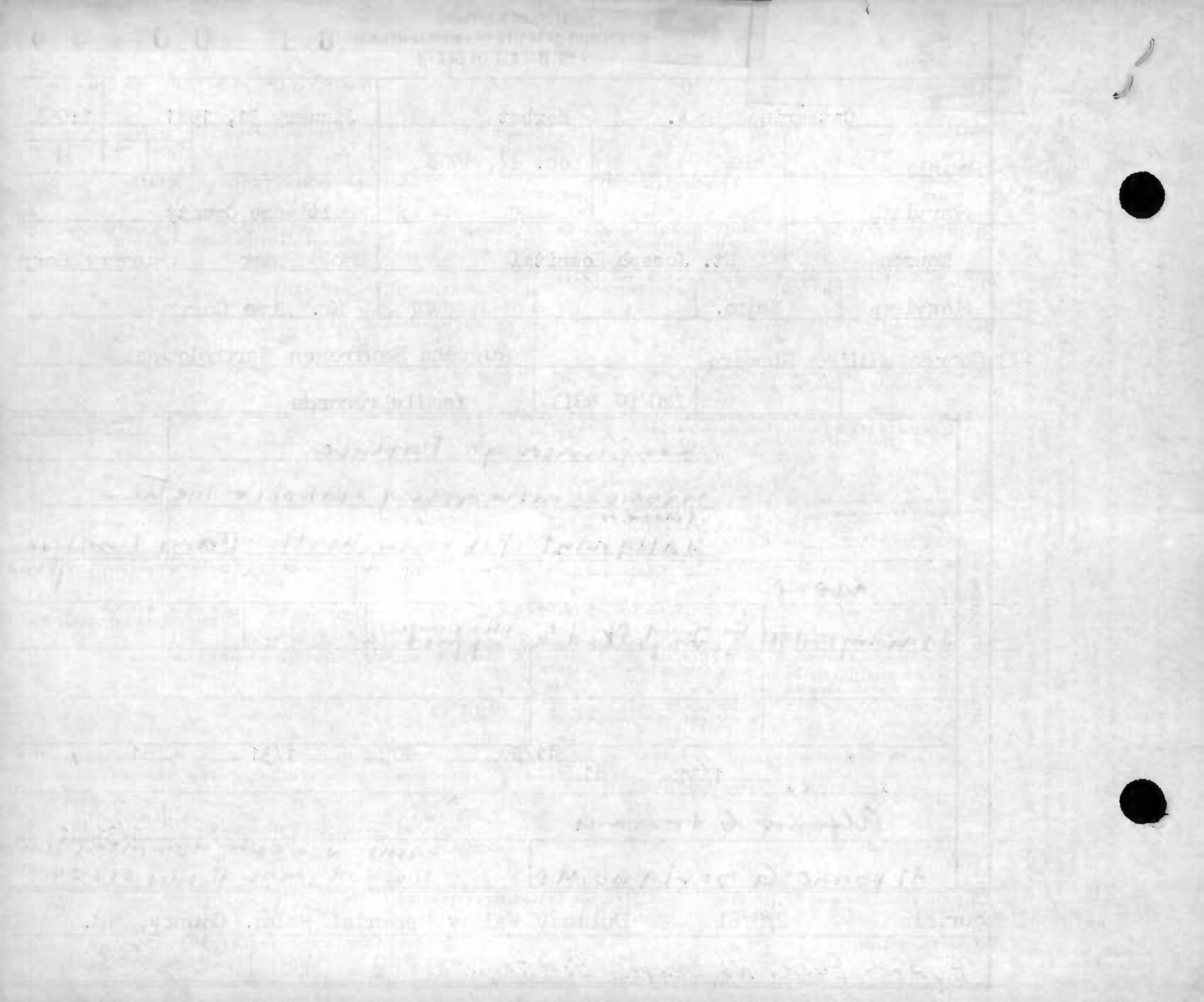
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |                            | 8100458                                      |  |
|---|--|---|--|---|--|--|--|--|----------------------------|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |  |                            |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Catherine A. Herbst</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 31, 1981</b>   |  |  | 2b. HOUR<br><b>1:05A M</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 12, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>75</b>  |                            | IF UNDER 24 HRS<br>HOURS MIN.<br><b>75</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Murray Corp</b>  |                            |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Balto.</b>  |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>6 St. Elmo Court</b>   |                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George William Siemens</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Augusta Stoffregen Bartholomaei</b>  |  |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220 07 4313</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>family records</b>  |  |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Massive pulmonary emboli + metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Malignant Fibrous Histiocytoma lumbar</b> |  |   |  |   |  |  |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>none</b>   |  |   |  |   |  |  |  |  |                            |  |  |
| 19a. DATE OF OPERATION<br><b>January 15, 1981</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Biopsy of tumor through retractor</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                            |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>11/28</b> , 19 <b>80</b> , to <b>1/31</b> , 19 <b>81</b> , that (we) lost<br>saw the deceased alive on <b>1/31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |                            |  |  |
| 22b. SIGNATURE<br><b>Alfonso G. Soriano</b>   |  |   |  |   |  | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/31/81</b>   |                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alfonso G. Soriano, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>Saint Joseph Hospital Inc.<br/>Towson, Maryland 21204</b>   |  |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>2/3/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. County, Md.</b>  |  |  |                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS FUNERAL Chapel 8800 Harbor Rd</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 6 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Hickey</b>  |                            |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8100459  |           |            |                       |
|---|--|---|--|---|--|---|--|--|--|--|-----------|------------|-----------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |  |           |            |                       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Walter   |  | MIDDLE  |  | LAST<br>Herchowski, SR.   |  | 2a. DATE OF DEATH  |  | MONTH<br>1   | DAY<br>20 | YEAR<br>81 | 2b. HOUR<br>2:38 A.M. |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 15 1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 74 HRS.<br>HOURS MIN.   |           |            |                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |  |           |            |                       |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC 6701 N. Charles St. 21204 |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Baker  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |           |            |                       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Parkville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1326 Heather Hill Rd.   |  |  |           |            |                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ignatius Herchowski   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maria Antoszewski  |  |   |  |  |  |  |           |            |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>213-34-2611   |  | 17. INFORMANT ADDRESS<br>Mrs. Ida Herchowski Same as # 13e                                      |  |  |  |  |           |            |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>  |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anterior M.I.</u>   |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>History of TIA's, Pneumonia</u>   |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |           |            |                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |           |            |                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |           |            |                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/6/81</u> , to <u>1/20/81</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/20/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |           |            |                       |
| 22b. SIGNATURE<br><u>Dean Mesologites, M.D.</u>   |  |   |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/20/81  |           |            |                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dean Mesologites, M.D.   |  |   |  | 22e. ADDRESS<br>6701 N. Charles St. 21204   |  |   |  |  |  |  |           |            |                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment  |  |   |  | 23b. DATE<br>Jan. 23, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |  |           |            |                       |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc.   |  |   |  | ADDRESS<br>Balto., Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |           |            |                       |



CONFIDENTIAL

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(S)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 81 00460  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Stewart P.C. Herwig   |  |   |  | 2b. HOUR A M<br>8:25 A   |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>06 28 13  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>67   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Villa Nrsng.Cntr. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Driver  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S.Gov't  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Balt.   |  | 13c. STREET ADDRESS<br>1617 S. Hanover St.  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>John G.; Herwig  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Grace Torr   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes   |  | 16b. SOCIAL SECURITY NO<br>W.W. II 218-10-5265  |  | 17 INFORMANT ADDRESS<br>Oliver Fennington, 1617 S. Hanover St.   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Elmo Gayoso  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br>1/23/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elmo Gayoso, M. D.  |  |   |  | 22e. ADDRESS<br>5411 Old Frederick Road, Balt., Md. 21229  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 26, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24 FUNERAL DIRECTOR NAME<br>McCully Funeral Home, 230 E. Fort Ave. Balto. Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 27 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

Elmo Goyoso, M. D. 2411 Old Frederick Road, Baltimore, Md. 21220

JAN 7 1981

*Handwritten signature*

yes W.W.II 218-10-5265 Give Remington, 1617 S. Hanover St.

John ; Herwig Grace Fox

Maryland Balt. X 1617 S. Hanover St.

Catonville Frederick Villa Hosp. Cntr. Driver U.S. Gov't

Maryland U.S.A. Baltimore County

Male White

Student Herwig

01 23 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-359-0030.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BERNICE HESS</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN 3 1981</b>  |  | 2b. HOUR<br><b>5<sup>30</sup> A.M.</b>  |   |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 2 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MICHIGAN</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. LYNNACRES MD.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3819 WASHINGTON AVE. (21207)</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>              |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. <del>BALTIMORE</del>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS RUBEN GOLDSTICK</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA RAE SHALIN</b>   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br><b>215-09-2646</b>   |  | 17. INFORMANT ADDRESS<br><b>MILTON HESS 9032 PIXIE CT. FAIRFAX, VA. (22031)</b>                 |   |  |  |  |  |
| II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic lung cancer</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b> |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>for me</b> 19 <b>then</b> to <b>several months</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>John Mann</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/3/80</b>   |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN MANN</b>   |  | 22e. ADDRESS<br><b>5212 SPRING LAKE WAY</b>   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/4/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW CEM</b>                               |   |  |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>   |  | 23e. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW CEM</b>   |  | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>                             |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS</b>  |  | 6010 REISTERSTOWN RD.<br>BALTIMORE, MD. (21215)   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>7 1981</b>  |   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Mann</b>  |  |   |  |   |   |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 81 00462   |                  |  |                           |
|---|--|--|--|---|--|---|--|--|--|--|------------------|--|---------------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |  |  |  |                  |  |                           |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>ANNE</b>   |  | MIDDLE  |  | LAST<br><b>HEUER</b>  |  | 2a. DATE OF DEATH  |  | MONTH<br><b>1</b>                                    | DAY<br><b>31</b> | YEAR<br><b>81</b>                            | 2b. HOUR<br><b>5:30AM</b> |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 27, 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                       |                  |  |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |  |                  |  |                           |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MD.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clerical</b> |                  |  |                           |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>837 N. Milton Ave.</b>   |  |  |                  |  |                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Heuer</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Vobbe</b>  |  |   |  |  |  |  |                  |  |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-0349A</b>  |  | 17. INFORMANT<br><b>Pickersgill Home</b>  |  |   |  | ADDRESS<br><b>615 Chestnut Ave.</b>  |  |  |                  |  |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE ACUTE MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  |  |  |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |  |                  |  |                           |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                  |  |                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |                  |  |                           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |                  |  |                           |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>81</b> , to <b>1/31</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |   |  |  |  |  |                  |  |                           |
| 22b. SIGNATURE<br><i>Dr. C. Onejeme</i>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>1/31/81</b>   |  |  |                  |  |                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. C. ONEJEME</b>  |  | 22e. ADDRESS<br><b>GREATER BALTO. MEDICAL CTR.<br/>6701 N. CHARLES ST. TOWSON, MD.</b>   |  |   |  |   |  |  |  |  |                  |  |                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 2, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto., Md.</b>                       |  |  |  |  |                  |  |                           |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  | ADDRESS<br><b>1050 York Road</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>R. J. McCreedy</i>   |  |  |  |  |                  |  |                           |

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DR. C. C. JEFFE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 81 00463

|  |  |                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 1-28 1981 |  |  |  |  |  |  |  |  |  | 2b. HOUR <input type="checkbox"/> 1:00 <input type="checkbox"/> a.m. |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ROSSELL K. HEWSON</b>  |  |                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH <b>APR. 22, 1939</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>41 YRS.</b> |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  | 7c. DATE PRONOUNCED DEAD <b>1-28-1981</b>  |  | 7d. HOUR <input type="checkbox"/> 1:00 <input type="checkbox"/> a.m. |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>                                 |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>intersection Dance Mill&amp;Blenheim Rds.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>VICE PRESIDENT</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>MD.</b>  |  |                      |  | 13b. COUNTY <b>BALTIMORE</b>   |  |  |  | 13c. CITY OR TOWN <b>PHOENIX</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET ADDRESS <b>26 GLENBROOK DR. PHOENIX, MD.</b> |  |  |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>WILLIAM B. HEWSON</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>ELIZABETH HANCE</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>006-38-1292</b>  |  |  |  | 17. INFORMANT <b>JANE E. HEWSON</b>  |  |  |  | ADDRESS <b>26 GLENBROOK DR. PHOENIX, MD.</b>   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chest injuries</b><br><b>8150</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY <b>12:17AM 1-29-81</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>driver of auto/fixed object impact</b>                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>intersection of</b>   |  |  |  | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>Dance Mill&amp;Blenheim Rds. Baltimore Co., Md.</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Margaret Bebell</b>  |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b>  |  |  |  | DATE SIGNED <b>1-29-81</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>   |  |                      |  | 23b. DATE <b>1/30/1981</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>  |  |  |  | 23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>BALTIMORE MD.</b>                               |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME</b>   |  |                      |  | ADDRESS <b>6500 YORK RD. 21212</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1981</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>L. J. M. [Signature]</b>                                       |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8100464  |     |                                   |          |
|--|--|---|--|---|--|---|--|--|--|--|-----|-----------------------------------|----------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7. REG. NO.   |  |   |  |   |  |  |  |  |     |                                   |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR                              | 2b. HOUR |
| VIRGIL   |  | G.  |  | HOBBS   |  |   |  | 01   |  | 14   | 81  | 6:00 P.M.                         |          |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | # UNDER 1 YEAR   |  | # UNDER 24 HRS   |     |                                   |          |
| Male   |  | White   |  | 07 01 1888  |  | 92 YRS.   |  | MONTHS   |  | DAYS   |     | HOURS MIN.                        |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |     |                                   |          |
| MARYLAND   |  | U.S.A.  |  |   |  | BALTIMORE COUNTY MD   |  |  |  |  |     |                                   |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |     | 12b. KIND OF BUSINESS OR INDUSTRY |          |
| ARBUTUS  |  | 5225 Benson Avenue  |  |   |  |   |  |  |  | PIPE FITTER  |     | B & O R.R.                        |          |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |     |                                   |          |
| MARYLAND   |  | BALTIMORE   |  | ARBUTUS   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 5225 BENSON AVENUE, 21227                                      |  |  |     |                                   |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |  |     |                                   |          |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST   |  |   |  |   |  |  |  |  |     |                                   |          |
| GEORGE   |  | HOBBS   |  | GEORGEANNA UNKNOWN  |  |   |  |  |  |  |     |                                   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |   |  |  |  |  |     |                                   |          |
| NO   |  | 705-07-1663   |  | SADIE HOBBS 5225 BENSON AVENUE, 21227   |  |   |  |  |  |  |     |                                   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>AS CVD.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>3</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> |  |   |  |   |  |   |  |  |  |  |     |                                   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |  |  |     |                                   |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |     |                                   |          |
|  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |     |                                   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |     |                                   |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |     |                                   |          |
|  |  |   |  | July 19 56 to 1/14 81   |  |   |  |  |  |  |     |                                   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. 19 56 to 1/14 81, that (I) (we) lost saw the deceased alive on 19 56 to 1/14 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |  |   |  |   |  |  |  |  |     |                                   |          |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |   |  |  |  |  |     |                                   |          |
| I. EARL PASS, M.D.   |  |   |  | 1/16/81   |  |   |  |  |  |  |     |                                   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |  |  |  |     |                                   |          |
|  |  | 4001 WILKENS AVENUE, 21229  |  |   |  |   |  |  |  |  |     |                                   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY   |  | STATE  |     |                                   |          |
| BURIAL   |  | 01-17-81  |  | MOUNT OLIVET  |  | BALTIMORE CITY  |  | MARYLAND   |  |  |     |                                   |          |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |     |                                   |          |
| HUBBARD FUNERAL HOME, INC.   |  | 4107 WILKENS AVE.   |  | JAN 16 1981   |  |   |  |  |  |  |     |                                   |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 7 00465   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Wesley Bankard HOFFMAN   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 12, 1981   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 5, 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66<br>YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Delaware  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County' MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tool Maker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Martin Co.  |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Essex   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Hoffman  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Bankard  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT<br>ADDRESS<br>Louise Hoffman, wife Same   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Recurrent cerebrovascular accident</u><br>(c) <u>Cerebrovascular insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Urinary tract infection; sepsis; bronchial asthma</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 29</u> , 19 <u>80</u> , to <u>January 12</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 12</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Naeem Gauhar</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/12/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Naeem Gauhar M.D.  |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |  |
| 23a. BURIAL; CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1-14-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. ...</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   | MIDDLE           | LAST  | 2a. DATE OF DEATH               | MONTH  | DAY             | YEAR   | 2b. HOUR                                   | P.   |  |
|--|---------|---|------------------|---|---------------------------------|--|-----------------|--|--|--|--|
| SADYE  |         |   |                  | HOLTZMAN  | JANUARY 12, 1981                |  |                 |  | 9:45 M                                     |  |  |
| 3. SEX   | 4. RACE |   | 5. DATE OF BIRTH |   | 6. AGE (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS                            |  |  |
| FEMALE   | WHITE   |   | AUG. 25, 1908    |   | 72 YRS.                         |  | MONTHS          |  | DAYS                                       |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                 |  | BALTIMORE COUNTY MD.                       |  |  |
| MARYLAND   |         | USA   |                  |   |                                 |  |                 |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |   |                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                 | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| BALTIMORE  |         | 6350 RED CEDAR PLA., APT. 313   |                  |   |                                 | MERCHANT   |                 | RETAIL   |  |  |  |
| 13a. STATE   |         |   |                  | 13b. COUNTY   |                                 | 13c. CITY OR TOWN  |                 | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |
| MARYLAND   |         |   |                  | BALTO.  |                                 | BALTIMORE  |                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | APT. 313<br>6350 RED CEDAR PLA. #21209                         |  |
| 14. FATHER'S NAME  |         |   |                  | 15. MOTHER'S MAIDEN NAME  |                                 |  |                 |  |  |  |  |
| FIRST MIDDLE LAST<br>SAMUEL MEHLMAN  |         |   |                  | FIRST MIDDLE LAST<br>LENA GROSS   |                                 |  |                 |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |         |   |                  | 16b. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT  |                 |  |  |  |  |
| NO   |         |   |                  | 220-34-6285   |                                 | A. HARRY HOLTZMAN<br>6350 RED CEDAR PLA., APT. 313 #21209        |                 |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC ARREST</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Myocardial Infarction; Ischemic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>3 yrs</u> |         |   |                  |   |                                 |  |                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |   |                  |   |                                 |  |                 |  |  |  |  |
| 19a. DATE OF OPERATION   |         |   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 |  |                 | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |         |   |                  |   |                                 |  |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |         |   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                 |  |                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
|  |         |   |                  |   |                                 |  |                 |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                 |  |                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
|  |         |   |                  |   |                                 |  |                 |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1978</u> to <u>1/12</u> 19 <u>81</u> , that (I) (we) lost <u>12/26</u> 19 <u>80</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) did not view the body after death).   |         |   |                  |   |                                 |  |                 |  |  |  |  |
| 22b. SIGNATURE<br><u>Leon Kassel</u>   |         |   |                  | DEGREE<br><u>MD</u>   |                                 |  |                 | 22c. DATE SIGNED<br><u>1/13/81</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         |   |                  | 22e. ADDRESS  |                                 |  |                 |  |  |  |  |
| LEON KASSEL, M.D.  |         |   |                  | 2435 W. BELVEDERE AVE. BALTO., MD   |                                 |  |                 |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |   |                  | 23b. DATE   |                                 | 23c. NAME OF CEMETERY OR CREMATORY                               |                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |
| BURIAL   |         |   |                  | JAN. 14, 1981   |                                 | YOUNG HEBREW YONG MEN  |                 |  | BALTIMORE MARYLAND                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         |   |                  |   |                                 | 25a. DATE REC'D. BY REGISTRAR                                    |                 |  | 25b. REGISTRAR'S SIGNATURE                 |  |  |
| SOL LEVINSON & BROS., INC.   |         |   |                  |   |                                 | JAN 21 1981  |                 |  | <u>Rafael McCreedy</u>                     |  |  |
| 6010 REGISTER TOWN RD BALTO MD 21215   |         |   |                  |   |                                 |  |                 |  |  |  |  |





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 00467

REG. NO.

|   |  |   |   |   |  |   |   |  |  |  |
|---|--|---|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Milton L Honemann</u>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>01-06-81</u>                  |   |  | 2b. HOUR<br><u>4:55</u> P.M.  |   |  |  |  |
| 3. SEX<br><u>male</u>   |  | 4. RACE<br><u>Cauc.</u>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>12 11 17</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>63</u> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Balto Md</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Balto County</u> MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Cockeysville</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Broadmead Life Time Care Center</u> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Claims Rep. Insurance Company</u>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>MD</u>  |  |   | 13b. COUNTY<br><u>Balto Co</u>  |   | 13c. CITY OR TOWN<br><u>Towson</u>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>2 Country Court apt 3A</u> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Henry L Honemann</u>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Maude E. Wilson</u> |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br><u>WW II</u>  |  |   | 16b. SOCIAL SECURITY NO.<br><u>218-03-9361</u>                          |   | 17. INFORMANT<br>ADDRESS<br><u>Mrs. M. Catherine Honemann Same as #13.</u>     |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA TO LIVER</u><br><u>1579</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF <u>UNDETERMINED PROB. PANCREATIC</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10-24-80-7-1-81</u>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |   |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-19</u> 19 <u>80</u> to <u>1-6</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>12-31</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><u>F. Sanzaro MD</u>  |  |   |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>1-7-81</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>F. SANZARO MD</u>   |  |   |   |   | 22e. ADDRESS<br><u>BROADMEAD</u>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  |   | 23b. DATE<br><u>Jan. 8, 1981</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington Nat. Cem.</u>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Arlington, Virginia</u>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</u>   |  |   |   |   | ADDRESS<br><u>1050 York Road</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 9 1981</u>  |  | 25b. SIGNATURE<br><u>[Signature]</u>                 |  |

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(M)

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW/STP

10/10/01  
UNCLASSIFIED

10/10/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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#5,6, 11mG552 2/19/81 KAM

STATE OF MARYLAND

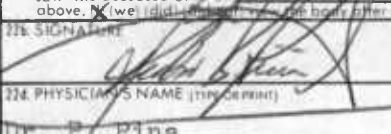
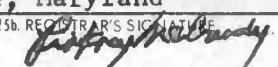
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1

0 0 4 6 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Alice G HOWARD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 24 1981</b>   |   | 2b. HOUR<br><b>4:20 pM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 11 1908</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71 72</b> YRS.  |   | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerical</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>  |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       | 13e. STREET ADDRESS<br><b>4308 Sheldon Avenue</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John L. Conway</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Stella C. Buckingham</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-10-5927</b>   | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, Md.</b><br><b>Lillian M. Baldwin 5134 Belair Road 21206</b> |   |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>2639</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple abscess</b>   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 2 1981</b> to <b>January 24 1981</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 24 1981</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not perform any post-mortem examination. |  |   |   |   |   |
| 22b. SIGNATURE<br>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/24/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. P. Pina</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 27, 81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Doppel Funeral Homes, Inc.</b>  |  | ADDRESS<br><b>7110 Belair Road<br/>Baltimore, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1981</b>   |   |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br> |   |

*[Faint, mostly illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

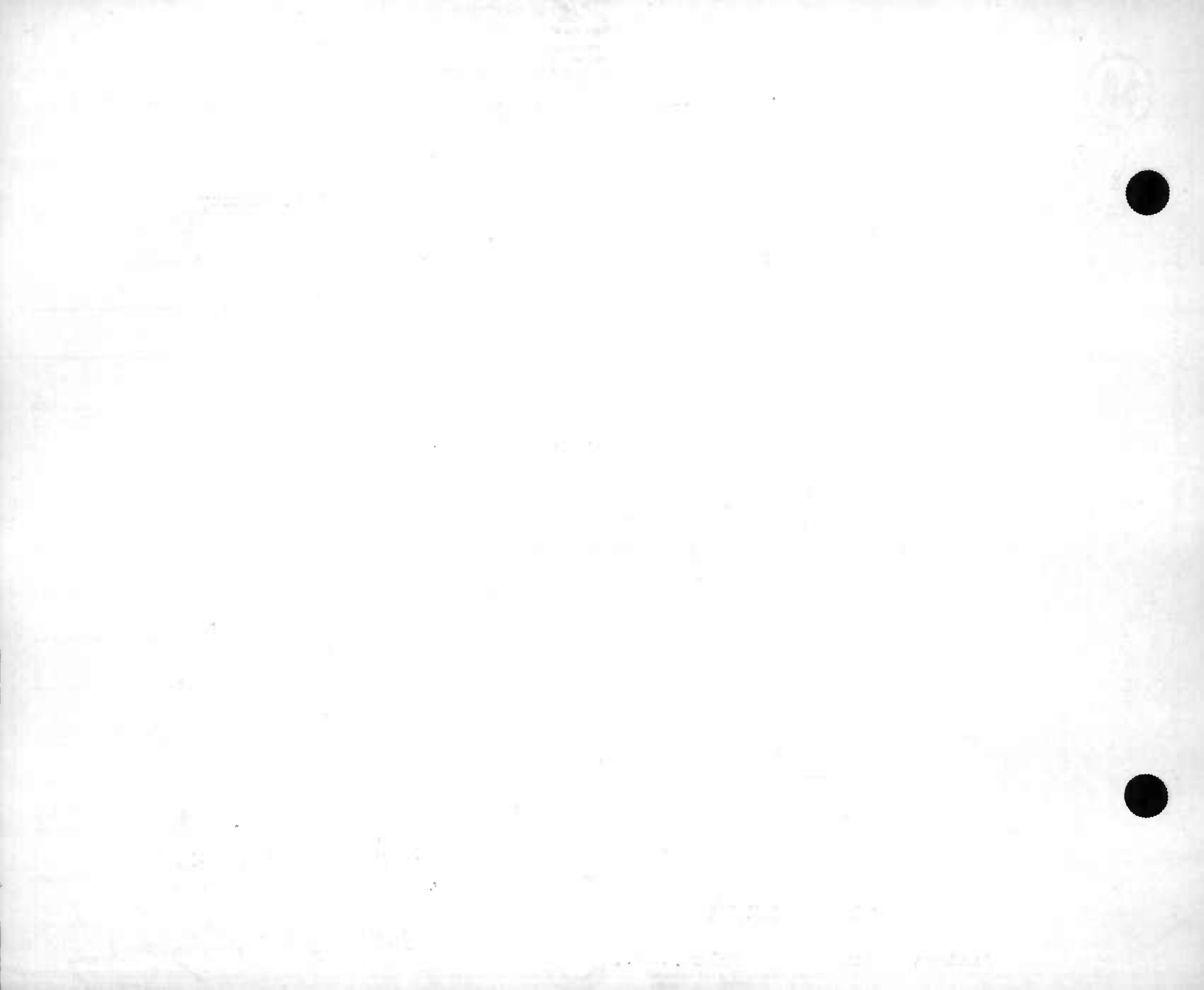
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 81 00469  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Granville H. Hubbard</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 3 - 81</b>   |  | 2b. HOUR <b>9 PM</b>  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 - 05 - 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cerroll Co</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Balto. Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Towers Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>  |  |
| 13a. STATE <b>Md</b> 13b. COUNTY <b>Cerroll</b>   |  |   |  | 13c. CITY OR TOWN <b>Westminster, Md</b>  |  | 13d. STREET ADDRESS <b>Unknown</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>N/A</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mrs. Mary Lee Hubbard</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>  |  | 16b. SOCIAL SECURITY NO. <b>219-54-3166</b>   |  | 17. INFORMANT ADDRESS <b>Westminster, Md</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1629 Bronchogenic Ca.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>10 - 4 - 19 77</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10 - 4 - 19 77</b> , to <b>1 - 3 - 19 81</b> , that (I) (we) (lost) saw the deceased alive on <b>1 - 3 - 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>H. Devados S</b> DEGREE <b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED <b>1-3-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Devados S</b>   |  |   |  | 22e. ADDRESS <b>BB Bldg. S.H.C.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>  |  | 23b. DATE <b>1/7/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>   |  |   |  | 25a. DATE FILED BY REGISTRAR <b>JAN 12 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

BP





1- FOR  
STATE  
REGISTRAR

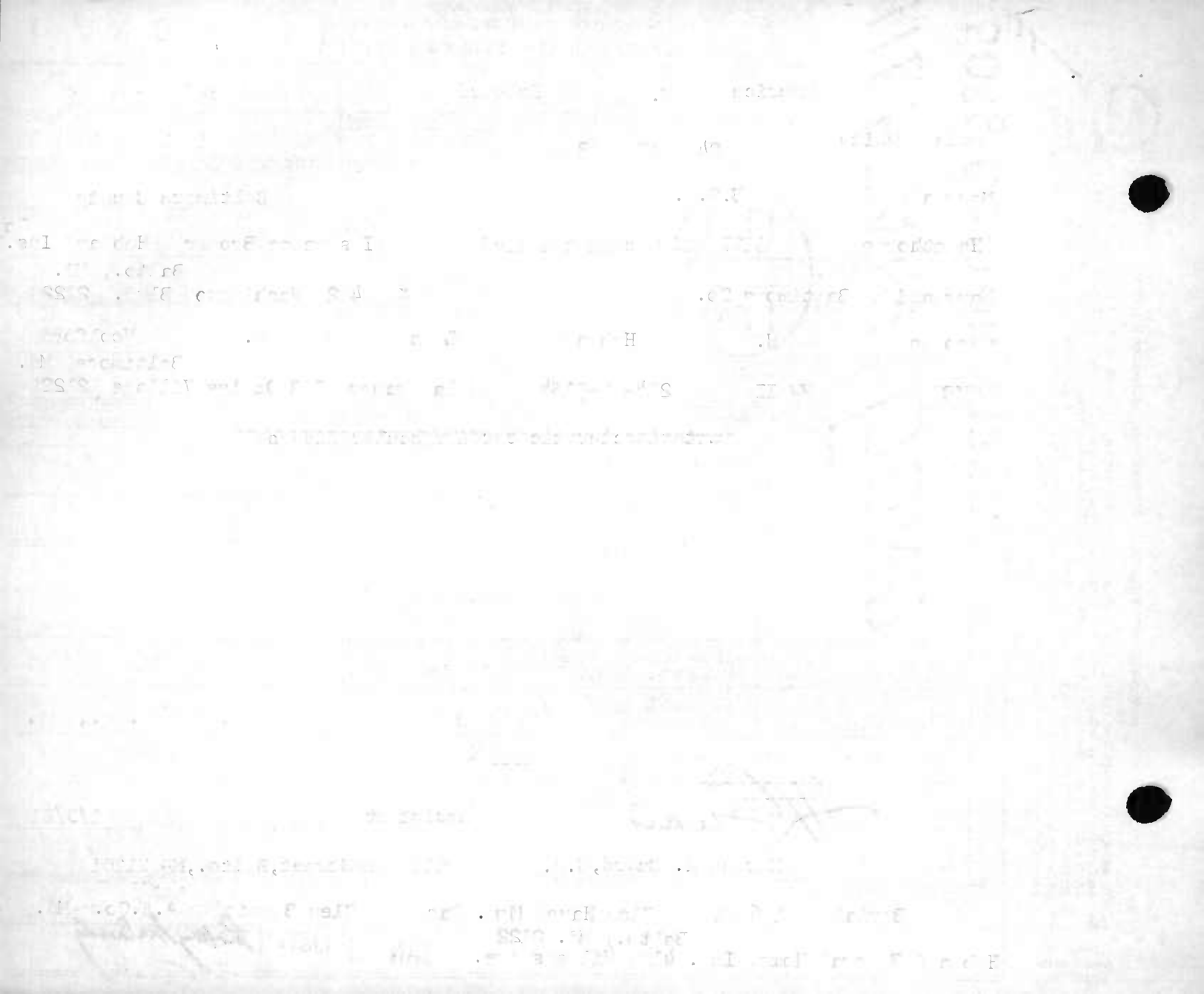
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00470

|   |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
|---|--|------------------|--|--|--|---|--|---|--|---|--|---|--|--|--|--|--|-------------------------------|--|------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Maurice |  | MIDDLE<br>W.   |  | LAST<br>Hubbard                               |  | 2a. DATE KNOWN<br>OF DEATH  |  | MONTH<br>1  |  | DAY<br>19   |  | YEAR<br>81   |  | 2b. HOUR<br>M                                      |  |                               |  |                  |  |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH<br>8 DAY<br>24 YEAR<br>17  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>63 YRS. |  | IF UNDER 1 YR.<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.                 |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  | MONTH<br>1 DAY<br>2 YEAR<br>81   |  | 2d. HOUR<br>M                                      |  |                               |  |                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |  |  |                               |  |                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Halethorpe   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4127 Old Washington Blvd |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Insurance Broker  |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Hubbard Ins. Co.  |  |  |  |  |  |                               |  |                  |  |  |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>Baltimore Co.   |  |   |  | 13c. CITY OR TOWN<br>Balto., Md.  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br>4127 Washington Blvd. 21227 |  |                               |  |                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>George  |  |                  |  | MIDDLE<br>W.   |  |   |  | LAST<br>Hubbard   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Lula   |  |  |  | MIDDLE<br>M.                                       |  |                               |  | LAST<br>Woelford |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>WW II  |  |   |  | 17. INFORMANT<br>Paula Kramer   |  |   |  | ADDRESS<br>Baltimore, Md.<br>353 Oaklee Village 21229   |  |  |  |  |  |                               |  |                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |                               |  |                  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| IMMEDIATE CAUSE (a) <del>Arteriosclerotic cardiovascular disease</del>  |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| 9801  |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.  |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| (b)   |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| (c)   |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                               |  |                  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. est. 1/19/81   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>self ingested  |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home   |  |   |  | 21f. LOCATION<br>STREET<br>4127 Old Washington Blvd., Balto. Co., Md.<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: <del>Natural causes</del> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| ACTUAL<br>SIGNATURE   |  |                  |  | TITLE (SPECIFY)<br>Assistant   |  |   |  |   |  |   |  |   |  | DATE<br>SIGNED 1/3/81  |  |  |  |                               |  |                  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |                  |  | Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201  |  |   |  |   |  |   |  |   |  |  |  |  |  |                               |  |                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>1/6/81  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park  |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>Glen Burnie A.A. Co. Md.<br>COUNTY<br>STATE                    |  |  |  |  |  |                               |  |                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  |                  |  |  |  |   |  |   |  | ADDRESS<br>Balto., Md. 21229<br>4107 Wilkens Ave. |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1981                              |  |  |  | 25b. SIGNATURE<br>[Signature] |  |                  |  |  |  |

 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |                                      |  |                                   |  |  |
|---|--|--|--|---|--------------------------------------|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH                                |  |   |                                      | 2b. HOUR   |                                   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH                                |  |   |                                      | 2b. HOUR   |                                   |  |  |
| ANNA M. HUGHES  |  | 1-9-81   |  |   |                                      | 3:30 P.M.  |                                   |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |                                      | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.   |  |
| F   | W  | 6 11 1890  |  | 90  |                                      | MONTHS DAYS  |                                   | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                   |  |  |
| Balt, Md  | U.S.A.   |  |  |   | Baltimore CO MD.                     |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                   |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Baltimore   | RIDGEWAY MANOR NURSING HOME  |  |  | Housewife   |                                      |  | 14 one                            |  |  |
| 13a. STATE  |  | 13b. COUNTY                                      |  | 13c. CITY OR TOWN   |                                      | 13d. INSIDE CITY LIMITS  |                                   | 13e. STREET ADDRESS  |  |
| Md  |  | BALTO.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |                                      | 2304 E. BIDDLE ST.   |                                   |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |                                      |  |                                   |  |  |
| JOHN TEUFEL   |  |  |  | HEDWIG KINVINKSKI   |                                      |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                         |  | 17. INFORMANT ADDRESS   |                                      |  |                                   |  |  |
| No  |  | 217-14-9982                                      |  | Mr. Wilson Hughes-13419 Jarrettville Pike                                       |                                      |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |                                      |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Carcinoma of Breast   |  |  |  |   |                                      |  |                                   |  | 5 yrs.                                       |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |                                      |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |                                      |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |                                      |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |                                      |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |   |                                      | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2) |                                      |  |                                   |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR                         |  |   |                                      |  |                                   |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                             |  | 21f. LOCATION   |                                      |  |                                   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET  |                                      | CITY OR TOWN COUNTY STATE  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 21, 1981, to Jan 21, 1981, that (I) (we) lost saw the deceased alive on Jan 21, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |                                      |  |                                   |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED   |  |
| William Goodman MD  |  |  |  |   |                                      |  |                                   | 9 Jan 81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |                                      |  |                                   |  |  |
| WILLIAM GOODMAN, MD   |  |  |  | 2102 North cliff Drive - Balt, Md 21209   |                                      |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      | 23d. LOCATION  |                                   |  |  |
| BURIAL  |  | 1-12-81  |  | BALTIMORE CEM.  |                                      | BALTO. MD.   |                                   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D BY REGISTRAR  |                                      | 25b. RECEIVED BY   |                                   |  |  |
| Name ADDRESS  |  |  |  | 25a. DATE REC'D BY REGISTRAR  |                                      | 25b. RECEIVED BY   |                                   |  |  |
| Janet Miller - 7527 Harford Rd.   |  |  |  | JAN 12 1981   |                                      |  |                                   |  |  |



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00472

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George R. Hunt, Jr.</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Eleanor C Hunt</b><br>Same  |  | 20. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH <input checked="" type="checkbox"/> 1 DAY 8 YEAR 1981   |  | 26. HOUR<br>6:00 AM   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH 7 DAY 16 YEAR 1915  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 65 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ind</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto Co.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Carney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9933 Hilltop Road</b> |  | 12. USUAL OCCUPATION<br><b>Industrial Production</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen. Mfg.</b>   |  |
| 13a. STATE<br><b>Ind</b>   |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Carney</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>George R. Hunt Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Mabel D. Triplett</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-4586</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c) PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>4100<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>(c) _____   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8-10 hr.</b>  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/12/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Acute Myocardial Infarction</b>  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Myocardial Infarction</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Frank T. Kasik, Jr.</b>   |  | TITLE (SPECIFY)<br><b>Asst. Deputy</b>   |  | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>1/8/81</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Frank T. Kasik, Jr.</b>  |  | ADDRESS<br><b>9005 Harford Road Balto. MD</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/12/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg, Maryland</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry H. H. H.</b>   |  |   |  |

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 81-00473   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>JANET C Hunt   |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR<br>1-29-81 9 24 1981   |  |  |  |
| 3. SEX<br>FEM  |  | 4. RACE<br>Cau.  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 24 91  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE Co. MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>STELLA MARIS Hospice |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>TOWSON  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>DANIEL Wilhere  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine Hagerty   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>141-05-4942  |  | 17. INFORMANT ADDRESS<br>STELLA MARIS Hospice Dulaney Valley Rd. 21204  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE <input checked="" type="checkbox"/> CHF<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <input checked="" type="checkbox"/> ADVANCED ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <input type="checkbox"/> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-18 19 80, to 1-29 19 81, that (I) (we) lost saw the deceased alive on 1-29 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>DRE. NAKUDA  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DRE. NAKUDA   |  |  |  | 22e. ADDRESS<br>STELLA MARIS Hospice Dulaney Valley Rd. Towson Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/31/1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>West Laurel Hill  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Montgomery Co PA.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Evans Funeral Chapel 8800 Hartford Rd   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 30 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Hagan  |  |





100% COTTON FIBRE

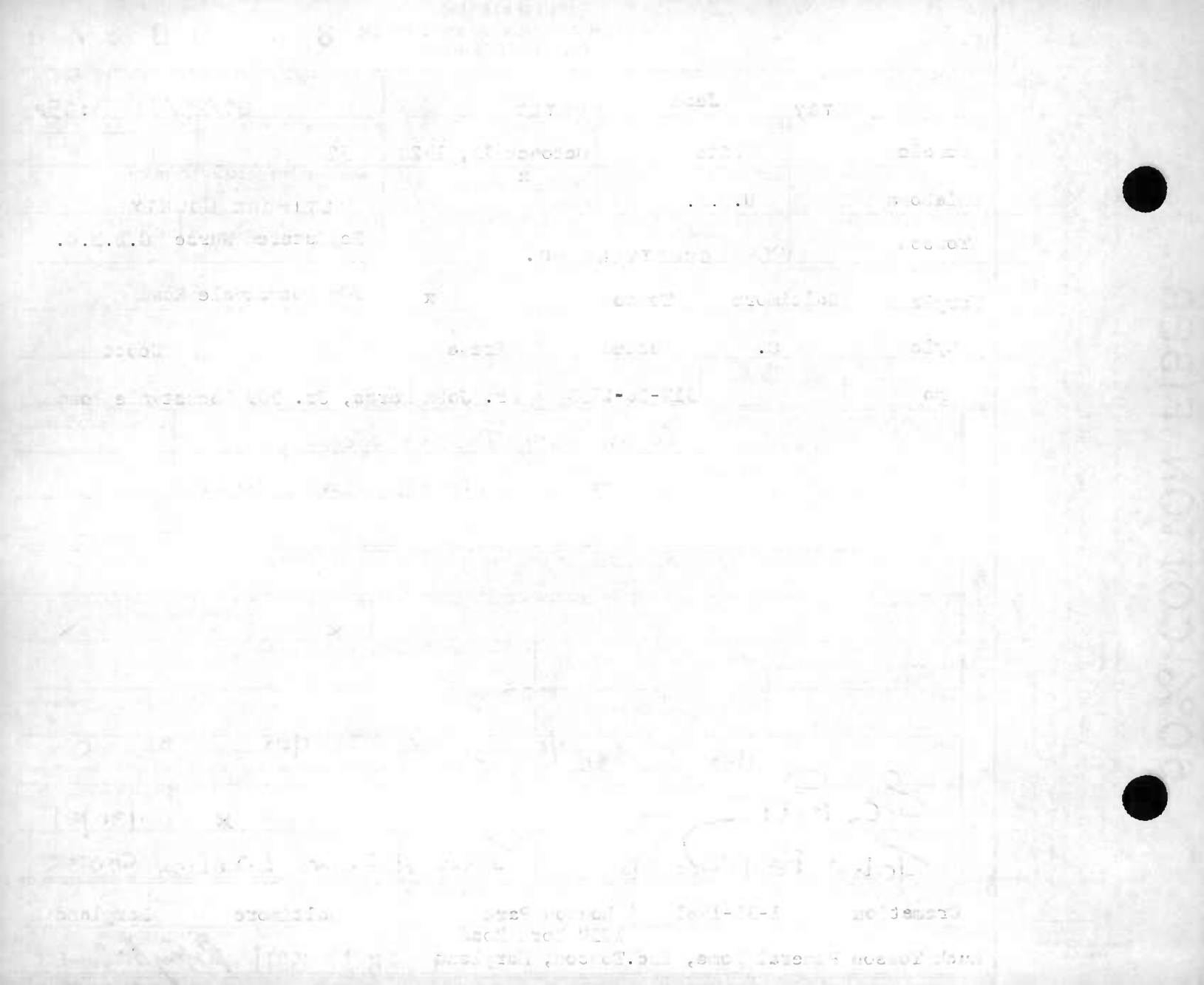
100% COTTON FIBRE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 81 00474  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br>PATSY Jean HUSTED   |  |   |  |   |  | MONTH DAY YEAR<br>01/29/81   |  |  |  | 3:15PM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  |
| Female   |  | White   |  | MONTH DAY YEAR<br>October 15, 1928  |  | 52   |  | MONTHS DAYS HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |   |  |
| Oklahoma   |  | U.S.A.  |  |   |  | BALTIMORE COUNTY MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |  |  |   |  |
| Towson   |  | 909 LOCUSTVALE RD.  |  |   |  |  |  |  |  |   |  |
| 12a. USUAL OCCUPATION (IF DECEASED FOR MOST OF WORKING LIFE)   |  |   |  |   |  |  |  |  |  |   |  |
| Registered Nurse   |  |   |  |   |  |  |  |  |  |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |  |  |  |  |  |   |  |
| G.B.M.C.   |  |   |  |   |  |  |  |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |  |  |   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |   |  |
| Maryland   |  | Baltimore   |  | Towson  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 909 Locustvale Road  |  |   |  |
| 14. FATHER'S NAME  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |
| FIRST MIDDLE LAST<br>Lyle C. Husted  |  |   |  |   |  | FIRST MIDDLE LAST<br>Irene Scott   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |
| No   |  |   |  | 513-26-2153   |  | Mr. John Maras, Jr. 909 Locustvale Road  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |  |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) PULMONARY Insufficiency.   |  |   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC Colonic CARCINOMA.   |  |   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |   |  |   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1, 1980, to 1/29, 1981, that (I) (we) lost<br>saw the deceased alive on 1/28, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>John Fetting   |  |   |  |   |  |  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 1/30/81   |  |
| John Fetting MD.   |  |   |  |   |  |  |  | 22e. ADDRESS<br>Johns Hopkins Oncology Center.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| Cremation  |  |   |  | 1-31-1981   |  | Loudon Park  |  | Baltimore Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson, Maryland  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
|  |  |   |  |   |  | 1050 York Road   |  | FEB 2 1981   |  |   |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |          |  |                  |  |  | 81 00475   |  |  |  |                          |  |   |  |                         |  |
|--|--|--|---|--|----------|--|------------------|--|--|--|--|--|--|--------------------------|--|---|--|-------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.  |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   |  | MIDDLE   |  | LAST             |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  |  | 2b. HOUR   |  |                          |  |   |  |                         |  |
| Anna   |  |  | N.  |  | IPPOLITO |  | January 10, 1981 |  |  | 6:25 am  |  |  |  |                          |  |   |  |                         |  |
| 3. SEX   |  |  | 4. RACE   |  |          | 5. DATE OF BIRTH   |                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  |  | 7. IF UNDER 1 YEAR   |  |                          |  |   |  |                         |  |
| Female   |  |  | White   |  |          | 8-13-1897  |                  |  | 83 YRS.  |  |  | MONTHS DAYS HOURS MIN.   |  |                          |  |   |  |                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  |  |  |                          |  |   |  |                         |  |
| Italy  |  |  | U.S.A.  |  |          |  |                  |  | Baltimore County MD.   |  |  |  |  |                          |  |   |  |                         |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |          |  |                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                          |  |   |  |                         |  |
| Rossville  |  |  | Franklin Square Hospital  |  |          |  |                  |  | seamstress   |  |  | Raleigh Mfg.   |  |                          |  |   |  |                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |          |  |                  |  |  |  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS      |  |   |  |                         |  |
| 13a. STATE Maryland  |  |  |   |  |          |  |                  |  |  |  |  | 13b. COUNTY Balto.   |  | 13c. CITY OR TOWN Balto. |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 29 Sipple Avenue Balto. |  |
| 14. FATHER'S NAME  |  |  |   |  |          | 15. MOTHER'S MAIDEN NAME   |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| FIRST MIDDLE LAST  |  |  |   |  |          | FIRST MIDDLE LAST  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| Arsenio Terranova  |  |  |   |  |          | Antoinette Saberito  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |   |  |          | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |                  | 17. INFORMANT ADDRESS  |  |  |  |  |  |                          |  |   |  |                         |  |
| NO   |  |  |   |  |          | 215-14-4435  |                  | George A. Ippolito 21 Sipple Ave.  |  |  |  |  |  |                          |  |   |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |          |  |                  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |                          |  |   |  |                         |  |
| IMMEDIATE CAUSE (a) Cardiac Arrest   |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 4275 DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| Diabetic Ketoacidosis  |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |          |  |                  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                          |  |   |  |                         |  |
|  |  |  |   |  |          |  |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                          |  |   |  |                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |          |  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |                          |  |   |  |                         |  |
|  |  |  |   | P.M. 19  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |          |  |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |                          |  |   |  |                         |  |
|  |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 9, 1981, to January 10, 1981, that (X) (we) last saw the deceased alive on January 10, 1981, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (X) (we) view the body after death. |  |  |   |  |          |  |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 22b. SIGNATURE   |  |  |   |  |          |  |                  |  |  |  |  | DEGREE   |  | 22c. DATE SIGNED         |  |   |  |                         |  |
| Rothbaum   |  |  |   |  |          |  |                  |  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 11/01/81                 |  |   |  |                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |          | 22e. ADDRESS   |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| ROTHBAUM   |  |  |   |  |          | 9000 Franklin Square Drive 21237   |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  |   | 23b. DATE  |          | 23c. NAME OF CEMETERY OR CREMATORY   |                  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |  |  |                          |  |   |  |                         |  |
| Burial   |  |  |   | 1-12-81  |          | Holy Redeemer Cemetery   |                  |  |  | Baltimore Maryland   |  |  |  |                          |  |   |  |                         |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  |   |  |          | ADDRESS  |                  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |                          |  |   |  |                         |  |
| Lassahn Funeral Home   |  |  |   |  |          | 7701 Belair Rd   |                  |  |  |  |  |  |  |                          |  |   |  |                         |  |

BP



BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |   |  |  |  |  |  | REG. NO. 000476  |  |
|--|--|----------------------|--|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                      |  |  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lorraine Marie Ireland</b>  |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>Jan. 9, 1981</b> |  |  |  | 2b. HOUR <b>M</b>  |  |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Dec. 20, 1927</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                                    |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                      |  |  |  |   |  |  |  |  |  |  |  |
| 13a. STATE <b>Pa.</b>  |  | 13b. COUNTY <b>✓</b> |  | 13c. CITY OR TOWN <b>Allentown</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>941 Penn Street</b>   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Ralph Milton Butz</b>  |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Florence F. Schellhamer</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>   |  |                      |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT ADDRESS <b>Rev. George Butz Main St. Valmeyer, Ill</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9805 IMMEDIATE CAUSE (a) Cardio Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>(b) Drug Overdosage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(c)</b>  |  |                      |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 days</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>paranoid Schizophrenia</b>   |  |                      |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . |  |                      |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>J.R. Norris</b> M.D.   |  |                      |  | TITLE (SPECIFY) <b>DEPUTY</b> MEDICAL EXAMINER   |  |   |  | DATE SIGNED <b>1-9-81</b>  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>J.R. NORRIS</b>   |  |                      |  | ADDRESS <b>342T SWEET AIR RD. PHOENIX</b>  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>Jan. 12, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Friedens</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Friedens Pa.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b> ADDRESS   |  |                      |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>R. J. Ruck</b>                   |  |  |  |

(M)

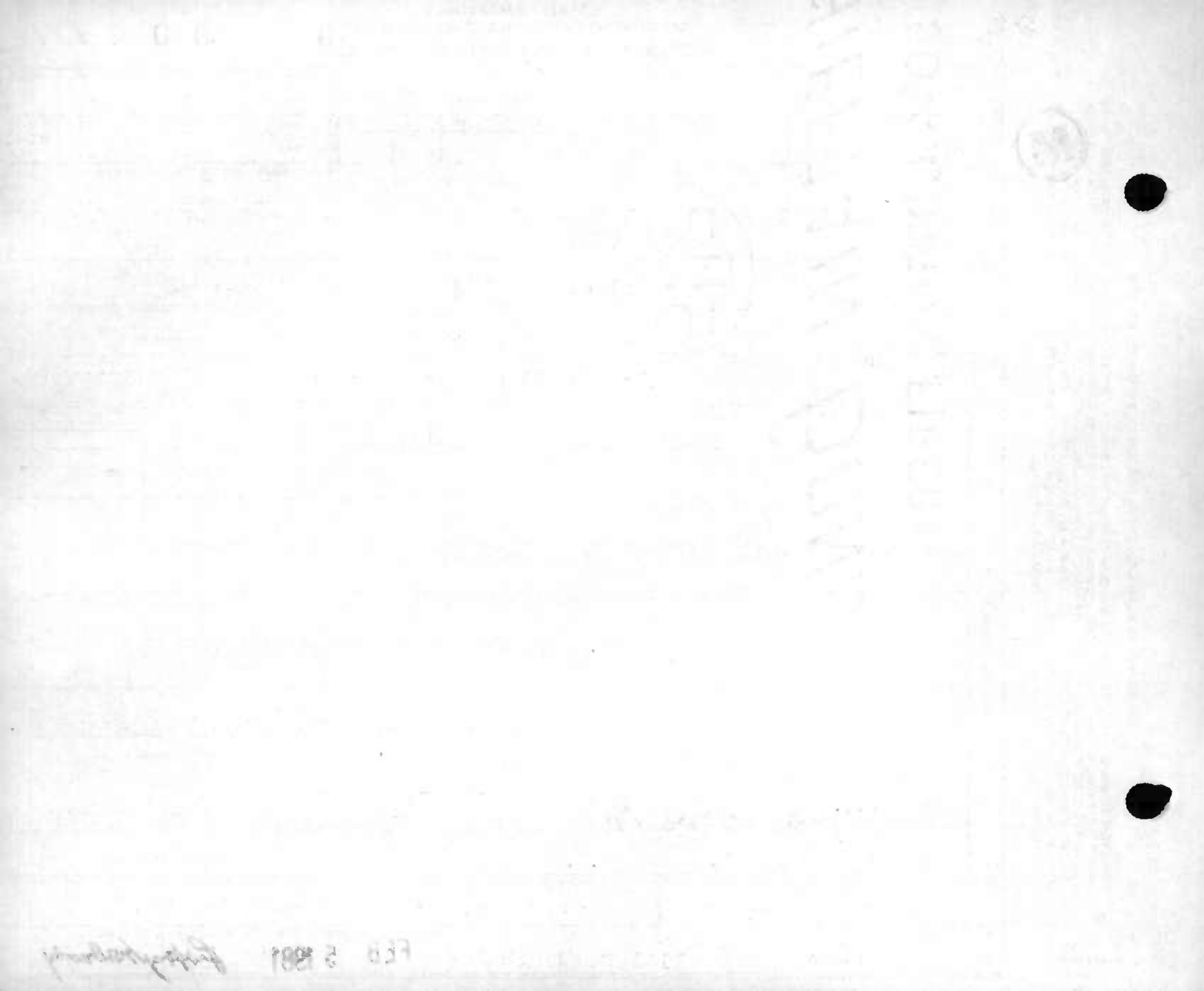


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITALS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |                      |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |                    |  |   |  |  |  |                                  |  |  |  |
|---|--|--|--|---|--|----------------------|--|---|--|---|--|--|--|---|--|---|--|---|--|--|--|--------------------|--|---|--|--|--|----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2. DECEASED NAME<br>(TYPE OR PRINT) <b>Robin</b> |  | 3. SEX <b>Female</b>  |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 27 56</b>   |  | 6. AGE IN YEARS<br>(LAST BIRTHDAY) <b>24 YRS.</b> |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |  | 9. DATE OF DEATH<br>KNOWN ESTIMATED <input checked="" type="checkbox"/> <b>1 2 1981</b> |  | 10. DATE OF DEATH<br>PRONOUNCED DEAD <b>1 26 1981</b> |  | 11. HOUR <b>4:41</b>   |  | 12. MIN <b>P M</b> |  |   |  |  |  |                                  |  |  |  |
| 13. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  |  |  | 14. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                 |  |                      |  | 15. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   |  | 16. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>   |  |   |  | 17. CITY OR TOWN OF DEATH <b>Owings Mills</b>   |  |   |  | 18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bonita Avenue</b> |  |                    |  | 19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  |  |  | 20. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| 21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 22. STATE <b>Md.</b>  |  |                      |  | 23. COUNTY <b>Balto.</b>  |  |   |  | 24. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 25. STREET ADDRESS <b>256 Bethel Ct.</b>  |  |   |  | 26. FATHER'S NAME<br>FIRST MIDDLE LAST <b>George Murray</b>  |  |                    |  | 27. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Ethel Gwynns</b>                   |  |  |  |                                  |  |  |  |
| 28. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |  |  | 29. SOCIAL SECURITY NO. <b>216-66-6721</b>                              |  |                      |  | 30. INFORMANT ADDRESS <b>Belton Isaac, Jr. 2328 Eutaw Pl.</b>   |  |   |  | 31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9660 IMMEDIATE CAUSE (a) Multiple Stab Wound of Chest</b> |  |   |  | 32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |                    |  |   |  |  |  |                                  |  |  |  |
| 33. CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |  |  | 34. DUE TO, OR AS A CONSEQUENCE OF (b)                                  |  |                      |  | 35. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  | 36. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                   |  |   |  | 37. DATE OF OPERATION   |  |   |  | 38. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                    |  | 39. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                                  |  |  |  |
| 40. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 41. TIME OF INJURY <b>Est. HOUR A.M. MONTH DAY YEAR ? P.M. 1 2 1981</b> |  |                      |  | 42. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject stabbed</b>   |  |   |  | 43. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |   |  | 44. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>embankment</b>            |  |   |  | 45. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>Bonita Avenue, Owings Mills, Baltimore, Md.</b>                          |  |                    |  |   |  |  |  |                                  |  |  |  |
| 46. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  | 47. TITLE (SPECIFY) <b>Assistant</b>                                    |  |                      |  | 48. DATE SIGNED <b>1/27/81</b>  |  |   |  | 49. EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |   |  | 50. ADDRESS <b>111 Penn Street</b>  |  |   |  |  |  |                    |  |   |  |  |  |                                  |  |  |  |
| 51. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  | 52. DATE <b>2/6/81</b>  |  |                      |  | 53. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>  |  |   |  | 54. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Catonsville, Md.</b>  |  |   |  | 55. DATE REC'D. BY REGISTRAR <b>FEB 5 1981</b>  |  |   |  | 56. REGISTRAR'S SIGNATURE <b>Robert H. H. H.</b>   |  |                    |  |   |  |  |  |                                  |  |  |  |
| 57. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>   |  |  |  | 58. ADDRESS <b>1101 E. North Ave</b>                                    |  |                      |  | 59. DATE REC'D. BY REGISTRAR <b>FEB 5 1981</b>  |  |   |  | 60. REGISTRAR'S SIGNATURE <b>Robert H. H. H.</b>   |  |   |  | 61. DATE REC'D. BY REGISTRAR <b>FEB 5 1981</b>  |  |   |  | 62. REGISTRAR'S SIGNATURE <b>Robert H. H. H.</b>   |  |                    |  |   |  |  |  |                                  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 81 00478  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ALEC ISAACSON</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-13-81</b>  |  |   |  |
| 3. SEX<br><b>M ALE</b>  |  |  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5, 1916</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  |  | 7. UNDER 1 YEAR MONTHS DAYS<br><b>06-01-17</b>   |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  |  | 9. UNDER 24 HRS. HOURS MIN.<br><b>2:34 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>INDUSTRIAL</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MORRIS ISAACSON</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>JENNIE WASSERMAN</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>220-07-4769</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. ESTHER GOLDSTEIN 3421 JANVALE RD. 21207</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1850 IMMEDIATE CAUSE (a) METASTATIC PROSTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____ |  |   |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br><b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES <input type="checkbox"/> NO <input type="checkbox"/></b> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>YES</b>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-13-</b> 19 <b>81</b> , to <b>1-13-</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1-13-</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>VANDYALA V. REDDY</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>1-13-81</b>  |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VANDYALA V. REDDY</b>   |  | 23b. ADDRESS<br><b>BALTO. COUNTY GEN. HOSPITAL RANDALLSTOWN, MD, 21133</b>   |  | 23c. DATE SIGNED<br><b>1-13-81</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-15-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON (CHIZUK AMUNO)</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1981</b>   |  |   |  |
| 25b. ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |  |  |  | 25c. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

UNITED MAIL LTD

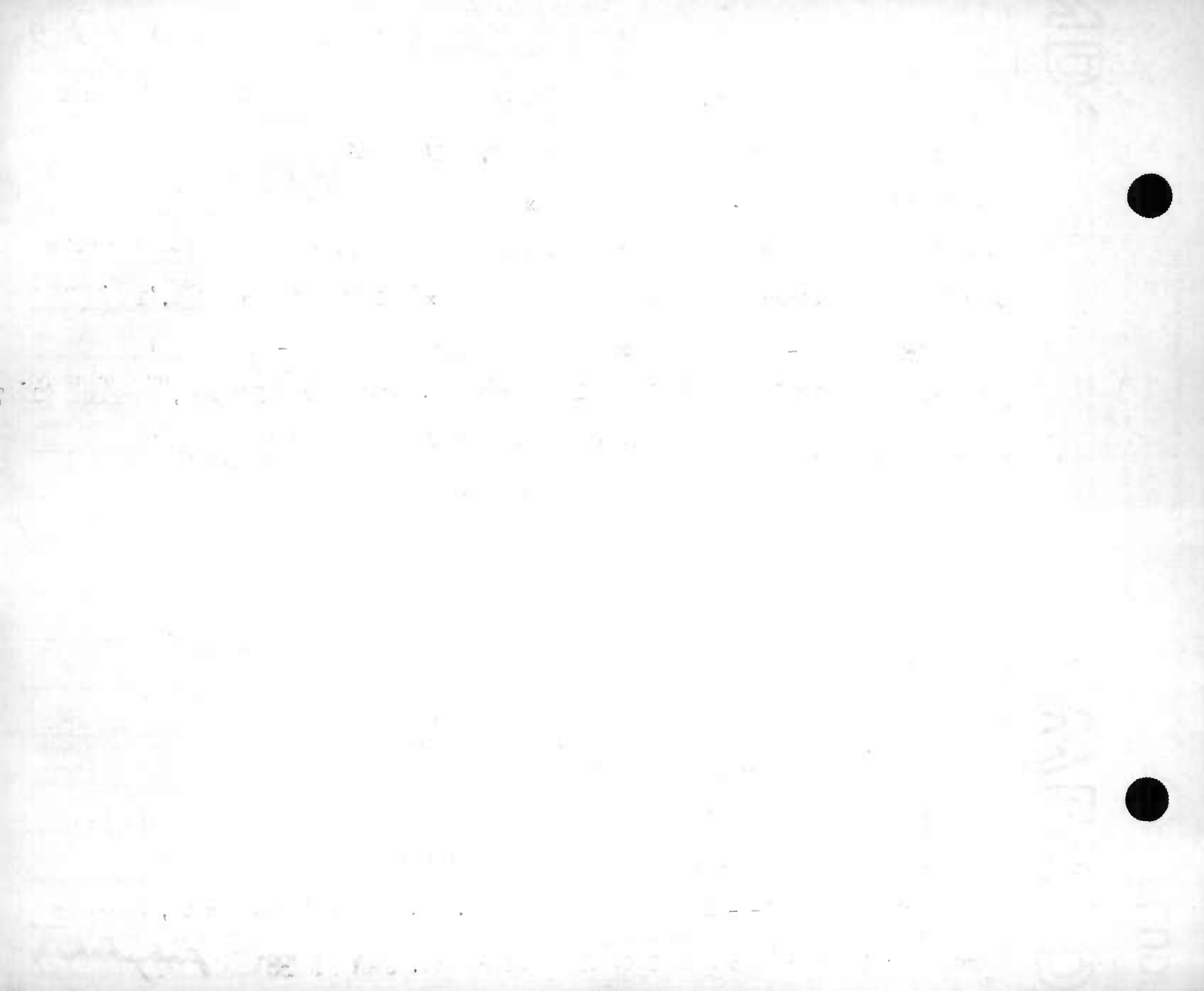
NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | 8100479   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Bela  |  | MIDDLE<br>L.  |  | LAST<br>JACOB   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 2 81   |  | 7b. HOUR<br>8:45 a<br>M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 12, 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66<br>YRS.   |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 9. IF UNDER 24 HRS<br>HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital                |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Welder                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Essex  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  | 13e. STREET ADDRESS<br>Baltimore, Md. 21221<br>1617 Gail Road Apt. #1 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nick - Simon  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena - ?   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>1936  |  | 17. INFORMANT<br>ADDRESS<br>Dorothy F. Rutkowski 1554 Sulphur Spring Rd.<br>Baltimore, Maryland 21222 |  |   |  |   |  |
| II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest; Arteriosclerotic vascular</u><br><u>disease</u><br>7850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of prostate.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/15/</u> 19 <u>80</u> , to <u>1/2/</u> 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/2/</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>A. Sant Antonio M.D.</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>1/2/81</u>   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Sant Antonio, M.D.  |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1-6-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Mem. Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland                              |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 1 0 0 4 8 0   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |  |  |   |  |   |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Vergie M. JAMES</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 5, 1981</b>                                   |  | 2b. HOUR<br><b>10:25 PM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 9 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1713 Melbourne Road</b>                                    |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Chewning</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maretta Jones</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-56-3033</b>   |  | 17. INFORMANT<br><b>Helen M. Wands</b>  |  | 1713 Melbourne Road<br><b>Balto., MD. 21222</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 1, 1981</b> , to <b>January 5, 1981</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 5, 1981</b> , and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Irving Cohen</i><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br><b>Jan 5, 1981</b>  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Irving Cohen M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>1/9/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1981</b>  |  |  |  |   |  |

MEDICAL CERTIFICATION





1935 WING AVENUE, LONDON, E.C. 8

12

M

1935 WING AVENUE, LONDON, E.C. 8

12

M

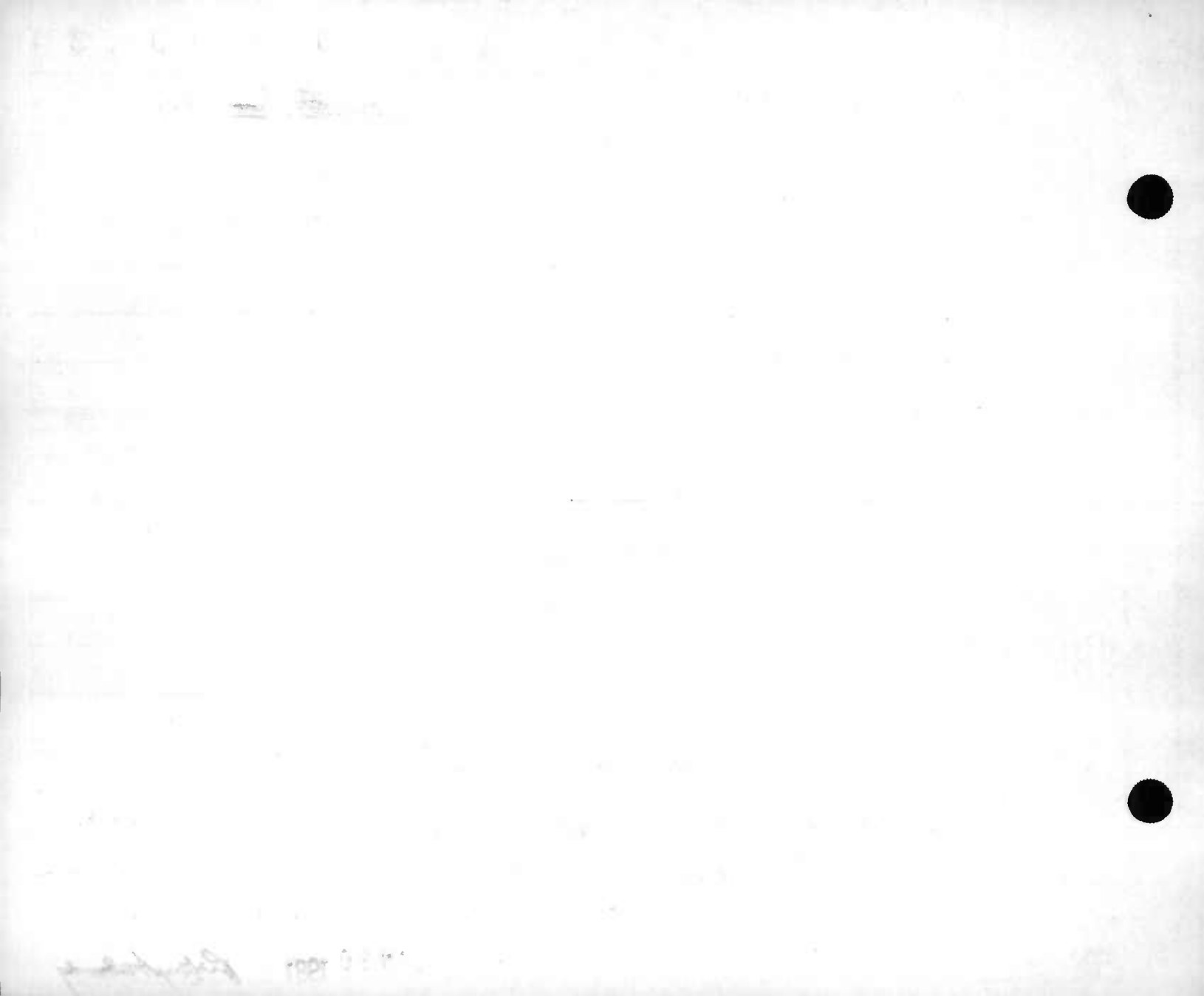
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 1 0 0 4 8 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Johanna K. Jaworski  |  |   |  | 2a. DATE OF DEATH<br>Jan. 26, 1981  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sep 8 1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Hampton House Apts. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>at home  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. STREET ADDRESS<br>204 E. Joppa Road   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Isadore Gorczewicz   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Johanna Wiesneski  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>213 62 4652   |  | 17. INFORMANT ADDRESS<br>family records   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>arterio sclerotic cerebrovascular disc.</u><br>4019<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5+ yrs<br>5+ yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 75, to Jan 1981, that (I) (we) lost saw the deceased alive on Jan 17, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Frederick J. Vollmer M.D.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1-28-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FREDERICK J. VOLLMER  |  |   |  | 22e. ADDRESS<br>6100 York Rd Baltimore, Md. 21212   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>entombment  |  | 23b. DATE<br>1/29/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Evans Funeral Chapel 8800 Harford Rd.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 30 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. K. K. K.   |  |

BP



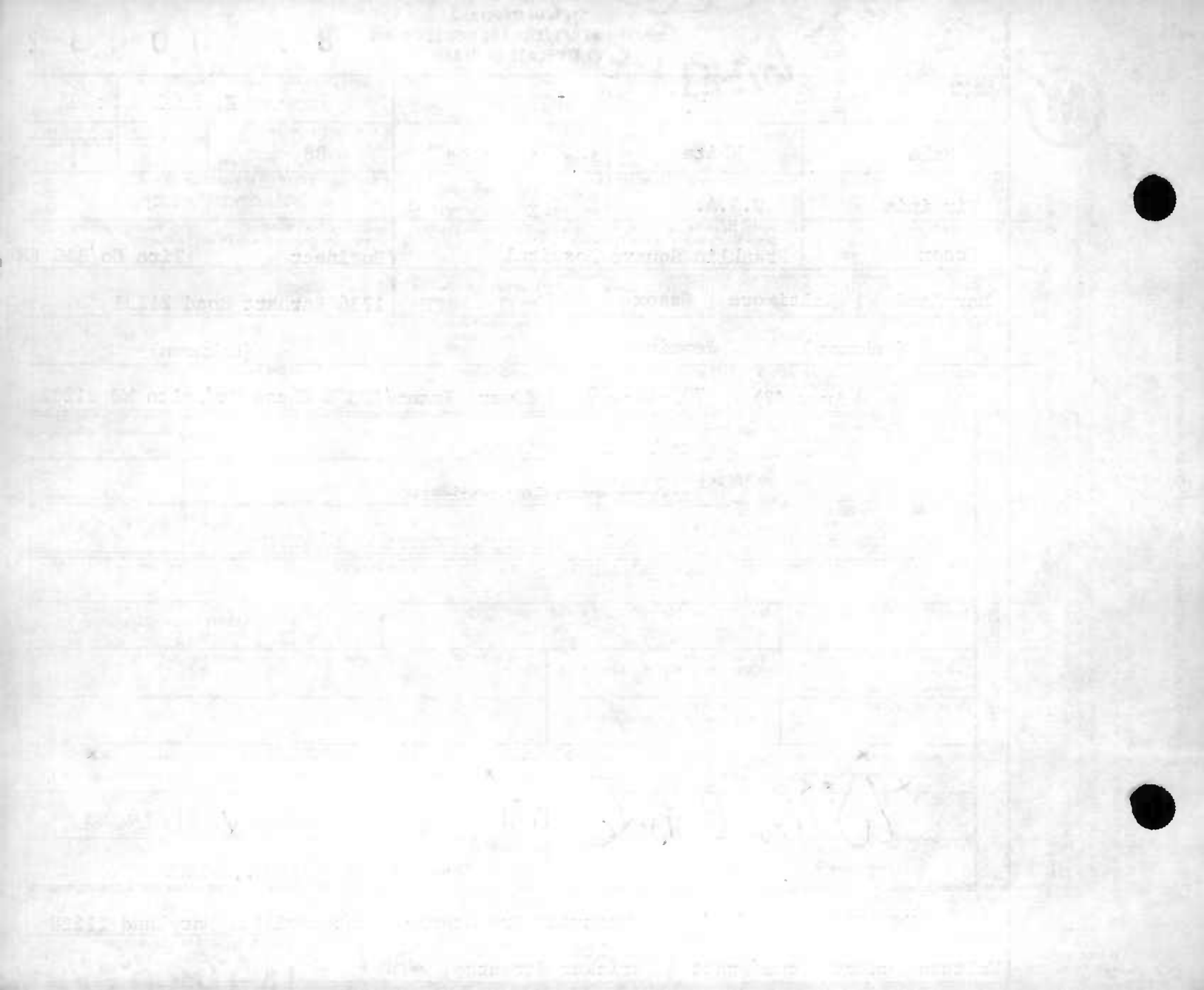
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8.1 00482   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Walter F. JENNINGS  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 4, 1981   |  |   |  |
| 3 SEX<br>Male   |  |  |  | 2b. HOUR<br>3:30A M   |  |   |  |
| 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Aug 1 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Essex  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tire Co/B&O RR   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE Maryland 13b COUNTY Baltimore 13c CITY OR TOWN Essex  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>(Unknown) Jennings   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>(Unknown)   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>705-10-8878  |  | 17. INFORMANT ADDRESS<br>Edward Franz/103 E Chase St/Balto Md 21202   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>                  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>December 24, 1980</u> to <u>January 4, 1981</u> , that (X) (we) last saw the deceased alive on <u>January 4, 1981</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>William A. Bode</u> MD  |  |  |  | 22c. DATE SIGNED<br>1/4/81  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM A. BODE  |  |
| 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |  | 22f. NAME OF CEMETERY OR CREMATORY<br>Westview Crematorium  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>01/05/81  |  | 23c. LOCATION CITY OR TOWN COUNTY STATE<br>Catonsville, Maryland 21228  |  | 23d. DATE REC'D. BY REGISTRAR<br>JAN 7 1981   |  |
| 24. FUNERAL DIRECTOR NAME<br>Walters Funeral Home/Pratt & Stricker Streets  |  |  |  | 25. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 0 0 4 8 3<br>REG. NO.   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 1. DECEASED NAME FIRST MIDDLE LAST<br><b>EDITH JENSEN</b>   |  |   |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 17 1981</b>  |  |   |  | 2b. HOUR MIN.<br><b>12:55 PM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 11, 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>70</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>13e. STREET ADDRESS<br><b>3550 Briar Vista Avenue</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Brittingham</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Florence Wonder</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>213 07 3178D<br/>220 12 5519</b>   |  | 17. INFORMANT ADDRESS<br><b>Miss Florence Palmer 3939 Roland Avenue</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>4280<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 DAYS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-6</b> , 19 <b>81</b> , to <b>1-17</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |   |  |
| 23a. SIGNATURE<br><b>J. BERGMAN</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-18-81</b>  |  |
| 22d. PHYSICIAN'S NAME (PRINT)<br><b>J. BERGMAN</b>  |  |   |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST. TOWSON MD 21204</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>  |  | 23b. DATE<br><b>1/21/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. G Cockeysville Balto.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Burgee Funeral Home</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 20 1981</b>  |  |   |  |

TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES

AND TO THE SENATORS

OF THE STATE OF NEW YORK

IN SENATE

JANUARY 18, 1901

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1901.

PRINTED BY THE STATE OF NEW YORK, 1901.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 7 1 0 0 4 8 4  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Herman E. Johnson   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Jan. 8, 1981                                  |  |  |  | 2b. HOUR<br>5:37a M  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 4, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7. IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Shirt Cutter     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Aetna Co.   |  |  |  |  |  |
| 13a. STATE<br>MARYLAND   |  |   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>UNKNOWN   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN                             |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-07-1724   |  | 17. INFORMANT<br>1014 Adcock Rd. Luther-ville, Md.<br>A Mr. John W. Yewell  |  |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4149 Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Arrhythmia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month                                      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Cardiac Arrhythmia</u>   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 4, 19 81, to Jan. 8, 19 81, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 8, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Mark Kaplan  |  |   |  | DEGREE<br>MD  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>Jan. 8, 1981   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mark Kaplan, M.D.   |  |   |  | 22e. ADDRESS<br>16918 York Rd. Monkton, Md. 21111   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-10-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEMETERY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND                    |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br>4210 BELAIR ROAD  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1981  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | 8100485   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Doris E. Jones</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 7, 1981</b>                                      |  |   | 2b. HOUR<br><b>12:50am</b>                                 |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10-9-1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                          |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                          |   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>301 McMEHEN ST.</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-38-7952</b>   |  | 17. INFORMANT ADDRESS<br><b>GEO. McLEAN 300 E. JOPPA RD.</b>  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4080</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Complete atelectasis left lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHF - DM Renal insuff.</b><br><b>CHF - DM, Renal INSUF</b>  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>78</b> , to <b>JAN 6</b> , 19 <b>81</b> , that <b>(I) (we)</b> last saw the deceased alive on <b>JAN 6</b> , 19 <b>81</b> , and that in <b>(my) (our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I) (we)</b> did not view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>L. Brown</b>   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <b>A</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Jan 7, 81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Boas, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>50 Scott Adam Rd. Cockeysville, Md. 21030</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-8-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY<br><b>BALTO. CO. MD</b>                                    |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>NEWELL F.H.</b>   |  |  |  | ADDRESS<br><b>1100 REISTERSTOWN RD.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. Brown</b>  |  |   |  |

THE  
CITY OF  
NEW YORK

175  
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JAN 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 0 0 4 8 6<br>REG. NO.   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Jones, Estelle</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 1, 1981</b>  |  |  |  | 2b. HOUR <b>11:45 A.M.</b>  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5-23-03</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>77</b> YRS.                             |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 8b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>             |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR-CARE ROSSVILLE</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNKNOWN</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS <b>3026 Overland Ave.</b>                                |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Stiffin</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>213-10-5808</b>   |  | 17. INFORMANT ADDRESS <b>EDWARD JONES 3026 Overland Ave. BALTIMORE 21214</b> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal cell cancer with Metastases</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1978</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension, A.S.C.V.D.</b>  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/18/80</b> to <b>1/1</b> 1981, that (I) (we) last saw the deceased alive on <b>1/1</b> 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  |  |  | DEGREE <b>M.D.</b> - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>1/1/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHIN M. TUN</b>   |  |  |  | 22e. ADDRESS <b>2-110 Pot Spring Road Balto md 21093</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>   |  | 23b. DATE <b>1/1/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                      |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 1 2 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                |  |   |  |

81

EXHIBIT D

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8100487  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. STATE REGISTRAR XC 23 746 234   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>CLAUDE AUSTIN JULIAN  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 1, 1981   |  | 2b. HOUR<br>9:50P <sup>M</sup>   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 3 15  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>INDIANA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD,  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>V. A. MEDICAL CENTER |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ser. Sta. Attnd.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ward Ser. Station   |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>Dundalk   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>DONALDSON H. JULIAN   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>LONA STEVENSON  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |  | 17. INFORMANT ADDRESS<br>Carrie Mae Julian Balto. MD, 21222   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u><br>4151<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>MALNUTRITION</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/22</u> , 19 <u>80</u> , to <u>1/1</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1/1</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Shirley Ann</i>   |  |   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br>1/2/1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SRINIVASAM L. NARASIMHAN, M. D.   |  |   |  | 22e. ADDRESS<br>V. A. MEDICAL CENTER, FORT HOWARD, MARYLAND   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/6/1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Shirley Ann</i>   |  |





RECEIVED

RECEIVED

NOTICE

RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 4 8 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Michael E. KALANDROS</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 3, 1981</b> |   |  | 2b. HOUR<br><b>12:45pm</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10<sup>TH</sup> 5<sup>DAY</sup> '08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b><br>YRS. MONTHS DAYS HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chef</b>                 |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Kalandros</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Athena</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-7028</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Nellie M. Kalandros</b><br><b>7244 Gough Street, Baltimore, Md.</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiac Arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**4275**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Dec. 30</b> , 19 <b>80</b> , to <b>Jan. 3</b> , 19 <b>81</b> , that (we) lost saw the deceased alive on <b>Jan. 3</b> , 19 <b>81</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Rothbaum</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/3/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROTHBAUM</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., Baltimore, Md.</b>   |  |  |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                |  | 23b. DATE<br><b>1-6-81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Anne Arundel Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Nicholas T. Matthews, 3021 Eastern Ave., Balt</b> |  |                            |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 6 1981</b>                |  | SIGNATURE<br><b>Pistroyhebody</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank T. Kasik</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan. 12, 1981</b>                   |   |  | 2b. HOUR<br><b>6:30a M</b>   |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 28, 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                        |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLOTHING CUTTER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GARMENT</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |   |   | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>6521 ROSEMONT AVE. 21206</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANTON KASIK</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY SOUL</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215 03 0311</b> |   | 17. INFORMANT<br>ADDRESS<br><b>DR. FRANK T. KASIK 6521 ROSEMONT AVE. 21206</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right lobe pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cerebrovascular thrombosis and stroke</b>  |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 31, 1980</b> , to <b>Jan. 12, 1981</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 12, 1981</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Abdulhamid Ghiladi</i>   |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>1-12-81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Abdulhamid Ghiladi, M.D.</b>  |  |   |   |   | 22e. ADDRESS<br><b>7600 Osler Dr. Towson, Md. 21204</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>1/15/1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEMORIAL CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>DIPPEL FUNERAL HOME 7110 BELAIR RD. BALTO. MD.</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>21 206 JAN 13 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey H. Brady</i>   |  |  |  |



DATE TIME

1981 JAN 13

00

WILLIAM H. H. . . .

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1981 JAN 13

WILLIAM H. H. . . .

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 8100490  |   |  |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>CHARLES HENRY KEEHNER SR.  |  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>01 05 81   |  |  | 2b HOUR<br>4:30 P.M.  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>WHITE  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>11 03 1896  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 8b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                                     |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>ARBUTUS   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1020 COURTNEY ROAD |   |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BOILER MAKER                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>B & O R.R.  |  |
| 13a STATE<br>MARYLAND   |  | 13b COUNTY<br>BALTIMORE  |   | 13c CITY OR TOWN<br>ARBUTUS  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br>1020 COURTNEY ROAD, 21227   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH UNKNOWN  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>WW I  |   | 17 INFORMANT<br>CHARLES H. KEEHNER, JR.  |  | 17 ADDRESS<br>214 A PRESTON CT.  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) LEFT SIDED PUMP FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) COMPLETE HEART BLOCK<br>NOT PACEMAKER |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from 8/22 1973 to 12/2 1980, that (I) (we) last saw the deceased alive on 12/2 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |   |  |  |  |  |   |  |
| 22b SIGNATURE<br>E. Kasattis M.D.   |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br>1/7/81  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDMUND D. KASATTIS, M.D.  |  |  |   |  | 22e ADDRESS<br>1801 FREDERICK ROAD,  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  | 23b DATE<br>01-08-81  |  | 23c NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.   |  |  |   |  | ADDRESS<br>21229<br>4107 WILKENS AVE.  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 7 1981                           |   |  |



COMMERCIAL BANK  
LAST 21st FUND FILLING  
MAY 20th 1918

18/181  
12/12  
12/12  
12/12

JAN 1 1918



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 1 0 0 4 9 1  |  |  |                                   |  |
|---|--|--|--|--|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mildred</b>   |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-20-81</b> |  |  | 2b. HOUR<br><b>1:30 P.M.</b>   |                                   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 30, 1896</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>   |                                   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Summitt Nursing Home</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late David Lescallett</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Lovella Lescallett</b>  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>Eugene Lappe 1457 Forest Park Ave 21207</b>   |  |  |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>A SCVD, CHF, old CVA, catenals</b>   |  |  |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION<br><b>-</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>1/19/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |  |  |                                   |  |
| 22b. SIGNATURE<br><b>James Evans</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>1/20/81</b>   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Evans</b>   |  |  |  | 22e. ADDRESS<br><b>1132 N Rolling Rd, Catonsville, Md 21228</b>  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>  |  | 23b. DATE<br><b>Jan 22 '81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorra ne Pk Mausoleum</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Maryland</b>   |                                   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>   |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 27 1981</b>   |  |  |                                   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |                                   |  |

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BT 02

Delaware C. 1900

Monmouth

Delaware C. 1900

Delaware C. 1900

Delaware C. 1900

1900 7 3 1901

TO HOSPITAL-OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy must be performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |        |  |      |  |                                     | 8100492  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--------|--|------|--|-------------------------------------|--|------|-----------------|-------|-----|-----------------|----|------|--------------------|----------|--|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |        |  |      |  |                                     | REG. NO.   |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  | MIDDLE |  | LAST |  |                                     | 2r. DATE OF DEATH  |      |                 | MONTH |     | DAY             |    | YEAR |                    | 2b. HOUR |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| WILLIAM   |  |  | H.  |  | KEENER |  |      |  |                                     |  | JAN. |                 |       | 17. |                 | 81 |      | 5 <sup>15</sup> AM |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 3 SEX   |  |  | 4 RACE  |  |        | 5 DATE OF BIRTH  |      |  | 6. AGE (IN YEARS LAST BIRTHDAY)     |  |      | IF UNDER 1 YEAR |       |     | IF UNDER 24 HRS |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Male  |  |  | white   |  |        | December 9, 1892   |      |  | 88                                  |  |      | MONTHS          |       |     | DAYS            |    |      | HOURS              |          |  | MIN. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| West Virginia   |  |  | USA   |  |        |  |      |  | Baltimore County MD.                |  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |        |  |      |  |                                     |  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Towson  |  |  | Dulaney Nursing & Convalescent Home   |  |        |  |      |  |                                     |  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |        |  |      |  |                                     |  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Miner   |  |  | Coal Company  |  |        |  |      |  |                                     |  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |        |  |      |  |                                     | 13b. CITY OR TOWN  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |  |   |  |        |  |      |  |                                     | 13b. COUNTY  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |   |  |        |  |      |  |                                     | Baltimore  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 14 FATHER'S NAME  |  |  |   |  |        |  |      |  |                                     | 15. MOTHER'S MAIDEN NAME   |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| FIRST   |  |  |   |  |        |  |      |  |                                     | FIRST  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Unknown   |  |  |   |  |        |  |      |  |                                     | Unknown  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |   |  |        |  |      |  |                                     | 16b. SOCIAL SECURITY NO.   |      |                 |       |     |                 |    |      |                    |          | 17 INFORMANT   |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| No  |  |  |   |  |        |  |      |  |                                     | -  |      |                 |       |     |                 |    |      |                    |          | 236 03 7446  |      |  |  |  |  |  |  |  |  | William Keener, Son                        |  |  |  |  |  |  |  |  |  | Same |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHRONIC ARTERIOSCLEROSIS</u>  |  |  |   |  |        |  |      |  |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6+ YR</u>           |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic Brain Syndrome</u>  |  |  |   |  |        |  |      |  |                                     |  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |   |  |        |  |      |  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |      |                 |       |     |                 |    |      |                    |          | 20a. AUTOPSY?  |      |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
|   |  |  |   |  |        |  |      |  |                                     |  |      |                 |       |     |                 |    |      |                    |          | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |      |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  |        |  |      |  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |      |                 |       |     |                 |    |      |                    |          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |  |        |  |      |  |                                     | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |      |                 |       |     |                 |    |      |                    |          | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-11-81</u> to <u>1-17-81</u> , that (I) (we) lost<br>saw the deceased alive on <u>1-17-81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |  |   |  |        |  |      |  |                                     | 22b. SIGNATURE<br><u>Donald Wood, M.D.</u>                             |      |                 |       |     |                 |    |      |                    |          | DEGREE   |      |  |  |  | 22c. DATE SIGNED<br><u>1/17/81</u>                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  |        |  |      |  |                                     | 22b. ADDRESS   |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Donald Wood, M.D.   |  |  |   |  |        |  |      |  |                                     | 2 Greenmeadow Dr., Timonium, Md. 21093                                 |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  |   |  |        |  |      |  |                                     | 23b. DATE  |      |                 |       |     |                 |    |      |                    |          | 23c. NAME OF CEMETERY OR CREMATORY   |      |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |   |  |        |  |      |  |                                     | 2-19-81  |      |                 |       |     |                 |    |      |                    |          | Holly Hill Mem. Gardens  |      |  |  |  |  |  |  |  |  | Baltimore County, Maryland                 |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Druzdinski Funeral Home</u>  |  |  |   |  |        |  |      |  |                                     | 25a. DATE REC'D. BY REGISTRAR  |      |                 |       |     |                 |    |      |                    |          | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McCreedy</u>                         |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |
| PA 1407 Old Eastern Ave.  |  |  |   |  |        |  |      |  |                                     | JAN 20 1981  |      |                 |       |     |                 |    |      |                    |          |  |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |      |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |                                   |  |   |  |
|--|--|---|--|---|--|--|-----------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 8100493  |  |                                   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Gertrude Lillian Kehoe   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 23, 1981           |  |                                   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 3 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90  |                                   | 7b. HOUR<br>M  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Cockeysville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10313 Malcolm Cr., Cockeysville |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |   |  |
| 13a. STATE<br>Md.  |  |   |  |   | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Cockeysville |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William B. Miles  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary E. Spellman |  |                                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>-----   |  | 17. INFORMANT<br>Mrs. Geraldine J. Ridgely  |  | ADDRESS<br>10313 Malcolm Cr., Cockeysville, Md.  |                                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio Vascular Disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |                                   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |                                   |  |   |  |
| 19a. DATE OF OPERATION<br>11/18/80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Peripheral Vascular Disease   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |                                   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>NOV. 29th</u> , 19 <u>76</u> , to <u>JAN. 23rd</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>JAN. 20th</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.               |  |   |  |   |  |  |                                   |  |   |  |
| 22b. SIGNATURE<br><u>Kevin Quinn</u> M.D.  |  |   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br>1-26-81  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kevin Quinn, M. D.  |  |   |  | 22e. ADDRESS<br>1205 York Road  |  |  |                                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/26/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Nat'l. Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |                                   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>J. E. Lowell Lemmon   |  |   |  | ADDRESS<br>10 W. Padonia Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 27 1981   |                                   | 25b. REGISTRAR'S SIGNATURE<br><u>Rita M. Brady</u>   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 81 00494   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |
| FIRST MIDDLE LAST<br><b>India Budd KE'NINGHAM</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 27 81</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  |  |  | 2b. HOUR<br><b>4<sup>40</sup></b> M   |  |  |  |
| 4. RACE<br><b>Caucasion</b>   |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 16, 1884</b>   |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.   |  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE ROSSVILLE</b> |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  |  |  |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13d. STREET ADDRESS<br><b>6415 Glenoak Ave.</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Watson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Budd</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-10-8203A</b>   |  |  |  |
| 17. INFORMANT ADDRESS<br><b>Mary K. Basler, 6415 Glenoak Ave.</b>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>F.H.D.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Senile dementia</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/20 3/17 19 79</b> to <b>1/27 19 81</b> , that (I) (we) lost saw the deceased alive on <b>1/26 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>N. Haroun</b>  |  |  |  | 22c. DATE SIGNED<br><b>1/28/81</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NAJI HAROUN</b>   |  |  |  | 22e. ADDRESS<br><b>9101 Franklin Sq. Dr., Balto. 21237</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>Jan. 31 1981</b>  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Ch.</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Hamstead, Carroll, Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1981</b>   |  |  |  |
| 6009 Harford Rd., Balto., Md. 21214   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |



*Handwritten signature*

Page 2 of 2

CONFIDENTIAL  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]

[Illegible body text]

[Illegible body text]

India and Kinnelham  
C. [Illegible]  
1 27 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 81 00495   |  | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARIE T. KELLER  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JAN. 30, 1981   |  | 2b. HOUR<br>M  |  |
| 3 SEX<br>F  |  | 4 RACE<br>W   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8/25/08  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>72  |  | 7. UNDER 1 YEAR MONTHS DAYS<br>7. UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. COUNTY MD.                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSEDALE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5717 HAMILTON |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>GOUT.                          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>ROSEDALE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>5717 HAMILTON AVE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EDWIN KNUDSEN  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY GOSSMAN  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>217 03146   |  | 17. INFORMANT ADDRESS<br>MARIE DARCHICOURT ABOVE   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction.</u><br>2500<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Sclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE <u>Barra</u>   |  |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>           |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARRA  |  |   |  | 22e. ADDRESS<br>7122 HARFORD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>2/2/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BELAIR MEMORIAL   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BELAIR MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>J.G. CONNELLY  |  |   |  | ADDRESS<br>300 MACE   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |

BP



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DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |                                    |                                 |  |  | 8100496  |  |                                   |  |   |  |
|---|--|--|--|---|--|------------------------------------|---------------------------------|--|--|--|--|-----------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |                                    |                                 |  |  | REG. NO.   |  |                                   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |   | FIRST MIDDLE LAST  |                                    |                                 |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  |                                   |  | 2b. HOUR  |  |
| Thelma  |  |  |  |   | Kendall  |                                    |                                 |  |  | 1-23-81  |  |                                   |  | 1 P M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY) |  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                   |  |   |  |
| Female  |  | White  |  | MONTH DAY YEAR<br>OCT 25 1901                                       |  |                                    | 79 YRS.                         |  |  | MONTHS DAYS  |  | HOURS MIN.                        |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                                   |  |   |  |
| Arkansas  |  | U.S.A.   |  |   |  |                                    |                                 | Baltimore County MD.   |  |  |  |                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |                                    |                                 |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |
| Randallstown  |  | Chapel Hill Nursing Home   |  |   |  |                                    |                                 |  |  | Beautician   |  | Self-employed                     |  |   |  |
| 13a. STATE  |  |  |  |   |  |                                    |                                 |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |  |  |   |  |                                    |                                 |  |  | Queen Annes  |  | Chester                           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME   |                                    |                                 |  |  | 13e. STREET ADDRESS  |  |                                   |  |   |  |
| FIRST MIDDLE LAST   |  |  |  |   | FIRST MIDDLE LAST  |                                    |                                 |  |  | Route 18   |  |                                   |  |   |  |
| John Wesley Irvin   |  |  |  |   | Clemmie Mozelle Branson  |                                    |                                 |  |  | Chester, Maryland  |  |                                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |   | 16b. SOCIAL SECURITY NO.   |                                    |                                 |  |  | 17. INFORMANT ADDRESS  |  |                                   |  |   |  |
| no  |  |  |  |   | 355-05-83234   |                                    |                                 |  |  | James H. McLeod<br>1039 East Marion Ave. Punta Gorda, Fla. 33950 |  |                                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |                                    |                                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |                                   |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |                                    |                                 |  |  | IMMEDIATE CAUSE (a)  |  |                                   |  |   |  |
| 4920  |  |  |  |   |  |                                    |                                 |  |  | ACUTE RESPIRATORY INFECTION                                      |  |                                   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                    |                                 |  |  | 1 Wk.  |  |                                   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |                                    |                                 |  |  | (b) OLD EMPHYSEMA  |  |                                   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                    |                                 |  |  | YEARS  |  |                                   |  |   |  |
| (c)   |  |  |  |   |  |                                    |                                 |  |  |  |  |                                   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |                                    |                                 |  |  |  |  |                                   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    |                                 | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |                                   |  |   |  |
|   |  |  |  |   |  |                                    |                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |                                   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |                                    |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                                   |  |   |  |
|   |  |  |  | P.M. 19   |  |                                    |                                 |  |  |  |  |                                   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |                                   |  |   |  |
|   |  |  |  |   |  |                                    |                                 |  |  |  |  |                                   |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>MARCH 1, 1977</u> to <u>JANUARY 23, 1981</u> , that (we) last saw the deceased alive on <u>1/22</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |                                    |                                 |  |  |  |  |                                   |  |   |  |
| 22b. SIGNATURE  |  |  |  |   |  |                                    |                                 |  |  | DEGREE   |  | 22c. DATE SIGNED                  |  |   |  |
| Martin S. Strobel   |  |  |  |   |  |                                    |                                 |  |  | MD   |  | 1/23/81                           |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  |                                    |                                 |  |  | 22e. ADDRESS   |  |                                   |  |   |  |
| MARTIN E. STROBEL   |  |  |  |   |  |                                    |                                 |  |  | REISTERSTOWN MD 21135  |  |                                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |                                 |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                          |  |                                   |  |   |  |
| Burial  |  |  |  | 1-26-81   |  | Lake View Mem. Park                |                                 |  |  | Eldersburg Carroll Md.   |  |                                   |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |   |  |                                    |                                 |  |  | 25a. DATE REC'D. BY REGISTRAR                                    |  | 25b. REGISTRAR'S SIGNATURE        |  |   |  |
| Loring Byers Funeral Directors P.A.<br>8728 Liberty Rd. Randallstown, Maryland 21133  |  |  |  |   |  |                                    |                                 |  |  | JAN 30 1981  |  | Loring Byers                      |  |   |  |

MEDICAL CERTIFICATION

1-28-81 19

Kendall

Thelma

Oct 25 1901

Female

is (Toward County

Chapel Hill (Toward County) Georgia

Oct 25 1901

is (Toward County

Chapel Hill (Toward County) Georgia



Oct 25 1901

Female

Thelma

Kendall

1-28-81 19

Chapel Hill (Toward County) Georgia

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 81 00497   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAUL KESSLER  |  | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 28, 1981  |  | 2b. HOUR 7:58 A.M.   |  |
| 3. SEX MALE  |  | 4. RACE WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 25, 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ST. LOUIS, MO  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDALLSTOWN CONVALESCENT CENTER |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VICE PRESIDENT  |  | 12b. KIND OF BUSINESS OR INDUSTRY MEEHANITE CORP.          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE NEW YORK 13b. COUNTY NEW YORK  |  |   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS 141 E. 33rd st. #10016  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACOB KESSLER  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE YAMPOLSKY  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO 063-03-5586   |  | 17. INFORMANT MRS. FRANCES KESSLER 141 E. 33rd ST., APT. 15B NEW YORK, NY 10016  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>3310 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alzheimer Disease, ASCU</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27/81 to 1/28/81, that (I) (we) lost saw the deceased alive on 1/27/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE Daniel Wilson   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 1/28/81  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DANIEL WILSON  |  | 22e. ADDRESS 3502 W. ROGERS AVE (21215)   |  |  |  |   |  |  |  |
| 23a. REMOVAL, REMOVAL (Type) BURIAL  |  | 23b. DATE 2/1/81  |  | 23c. NAME OF CEMETERY OR CREMATORY BNAI AMOONA   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE ST. LOUIS MISSOURI  |  |  |  |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 4 1981   |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |  |  |  |                                    |   |  |                          | 81 00498   |                                   |                 |  |          |  |
|--|--|------------------------------|--|--|--|------------------------------------|---|--|--------------------------|--|-----------------------------------|-----------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |                              |  |  |  |                                    |   |  |                          | REG. NO.   |                                   |                 |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  |  | FIRST MIDDLE LAST  |                                    |   |  |                          | 2a. DATE OF DEATH MONTH DAY YEAR                               |                                   |                 |  | 2b. HOUR |  |
| MARY   |  |                              |  |  | Clotoldis KIRCHNER   |                                    |   |  |                          | 1 5 '81  |                                   |                 |  | 3:27AM   |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |                          | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS |  |          |  |
| FEMALE   |  | WHITE                        |  | 06 22 1922   |  |                                    | 58  |  |                          | MONTHS DAYS  |                                   | HOURS MIN.      |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                          |  |                                   |                 |  |          |  |
| Maryland   |  | USA                          |  |  |  |                                    |   | BALTIMORE COUNTY MD.   |                          |  |                                   |                 |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                          |  | 12b. KIND OF BUSINESS OR INDUSTRY |                 |  |          |  |
| Towson   |  |                              |  | Greater Balto. Med. Center   |  |                                    |   | Clerical work-Lowey Drug Co  |                          |  |                                   |                 |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                              |  |  | 13b. COUNTY  |                                    | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS               |                 |  |          |  |
| Maryland   |  |                              |  |  | Baltimore  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3018 Northway Drive      |  |                                   |                 |  |          |  |
| 14. FATHER'S NAME  |  |                              |  |  | 15. MOTHER'S MAIDEN NAME   |                                    |   |  |                          |  |                                   |                 |  |          |  |
| FIRST MIDDLE LAST  |  |                              |  |  | FIRST MIDDLE LAST  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| John J Kirchner  |  |                              |  |  | Catherine Sammeth  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |                              |  |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS   |  |                          |  |                                   |                 |  |          |  |
| No   |  |                              |  |  | 220-07-8800  |                                    | Dolores C. Kirchner 3018 Northway Drive                             |  |                          |  |                                   |                 |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |  |                                    |   |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |                                   |                 |  |          |  |
| PART 1. DEATH WAS CAUSED BY:   |  |                              |  |  |  |                                    |   |  |                          | 20 MIN.  |                                   |                 |  |          |  |
| IMMEDIATE CAUSE (a) 1629   |  |                              |  |  |  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG   |  |                              |  |  |  |                                    |   |  |                          | 5 YEARS  |                                   |                 |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                              |  |  |  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |  |  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |  |  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    |   | 20a. AUTOPSY?  |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |                 |  |          |  |
|  |  |                              |  |  |  |                                    |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |                 |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                          |  |                                   |                 |  |          |  |
|  |  |                              |  | P.M. 19  |  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| 21d. INJURY OCCURRED   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)                                     |  |                                    |   | 21f. LOCATION  |                          |  |                                   |                 |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |  |  |  |                                    |   | STREET CITY OR TOWN COUNTY STATE   |                          |  |                                   |                 |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-29, 19 80, to 1-5-81, 19 81, that (I) (we) lost the deceased alive on 1-5, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |  |                                    |   |  |                          |  |                                   |                 |  |          |  |
| 22b. SIGNATURE   |  |                              |  |  |  |                                    |   | DEGREE   |                          | 22c. DATE SIGNED   |                                   |                 |  |          |  |
| Michael B. Grieco  |  |                              |  |  |  |                                    |   |  |                          | 1/05/81  |                                   |                 |  |          |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |  |  |  |                                    |   | 22e. ADDRESS   |                          |  |                                   |                 |  |          |  |
| MICHAEL B. GRIECO, M.D.  |  |                              |  |  |  |                                    |   | GBMC   |                          |  |                                   |                 |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  |                          | 23d. LOCATION  |                                   |                 |  |          |  |
| Burial   |  |                              |  | 1/8/81   |  | Most Holy Redeemer                 |   |  |                          | Baltimore Md.  |                                   |                 |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  |                              |  |  |  | 25a. DATE REC'D. BY REGISTRAR      |   | 25b. REGISTRAR'S SIGNATURE   |                          |  |                                   |                 |  |          |  |
| Lassahn Funeral Home   |  |                              |  |  |  | 7401 Belair Road                   |   | JAN 12 1981  |                          |  |                                   |                 |  |          |  |

2735 BP



BALTIMORE COUNTY

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WHITE

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CARDIORESPIRATORY ARREST

CARCINOMA OF LUNG

5 YEARS

1-1-81

1-1-81

1-1-81

MICHAEL A. GILLES, M.D.

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                  |   |  | REG. NO. 8100499  |  |  |  |          |
|---|------------------|---|--|---|--|--|--|----------|
| 1. FOR STATE REGISTRAR  |                  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>RITA LOUISE KIRKS   |                  |   |  | JAN. 11, 1981   |  |  |  | M        |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE | 5. DATE OF BIRTH MONTH DAY YEAR<br>JULY 23, 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON D.C.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |          |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7022 LACHLAN CIRCLE APT. C |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE  |                  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>7022 LACHLAN CIRCLE APT. C  |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>THOMAS YOUNG   |                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CLARA KREH  |  |   |  |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |                  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>220-46-6331   |  | 17. INFORMANT ADDRESS<br>DOROTHY Y. KIRKS 7022 LACHLAN CIRCLE 21239   |  |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) Acute C.H.F.<br>DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD   |                  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                  |   |  |   |  |  |  |          |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |          |
| 22. I certify that (I) (this hospital) attended the deceased from 1/12/81, to 1/12/81, that (I) (we) last saw the deceased alive on 1/12/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                  |   |  |   |  |  |  |          |
| 22b. SIGNATURE<br><i>Nestor M. Carmona</i>  |                  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/12/81  |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Nestor M. Carmona, M.D.  |                  | 22e. ADDRESS<br>6012 Harford Road   |  |   |  |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |                  | 23b. DATE<br>JAN. 14, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO..MD.   |  |          |
| 24. FUNERAL DIRECTOR NAME<br>MITCHELL-WIEDEFELD HOME  |                  | ADDRESS<br>6500 YORK RD. 21212  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony M. Brady</i>  |  |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical conditions must be certified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100500

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>XC 916 679   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 20, 1981   |  | 2b. HOUR<br>1:30 A.M.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>STRAWTHOR J. KISER   |  | 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPTEMBER 2, 1910  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>KENTUCKY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  | 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER - FT. HOWARD  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TRUCK DRIVER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BETH. STEEL   |  | 13a. STREET ADDRESS<br>5016 E. PRESTON STREET  |  |
| 13b. STATE<br>MARYLAND   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN KISER   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CECELIA PROFFITT  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |
| 16b. SOCIAL SECURITY NO.<br>1929-1935<br>213 10 7994   |  | 17. INFORMATION<br>CLINICAL RECORDS, VAMC, FORT HOWARD, MD   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFRACTION ACUTE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 7, 1981</b> , to <b>JANUARY 20, 1981</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 20, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/><br>22c. DATE SIGNED<br>1/20/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTINA B. FELICIANO, M.D.</b>   |  | 22e. ADDRESS<br><b>VAMC, FORT HOWARD, MD 21052</b>   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |
| 23b. DATE<br>1/23/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |  |
| 24. FUNERAL HOME, INC.<br>SCHEMUNEK FUNERAL HOME, INC.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Hebrink  |  |

NO 215 673

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TO

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U.S.A.

KENTUCKY COUNTY

JOHN HOWARD

VA MEDICAL CENTER

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2016 T. TRENCH STREET

1931-1932 215 10 7551 CIVILIAN RECORD, AMES, JOHN HOWARD, MD

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ARTIFICIAL INFLUENZA VIRUS

JANUARY 20, 1931 JANUARY 7, 1931 JANUARY 20, 1931

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CHRISTIAN P. KELLOGG, M.D. AMES, JOHN HOWARD, MD 21525

1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100501

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT L. KNIGHT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 24 1981</b>                         |   | 2b. HOUR<br>M<br><b>M</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 - 24 - 1905</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>75</b>                      |   | IF UNDER 1 YEAR<br>HOURS MIN.<br><b>75</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>PARKVILLE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2610 BURRIDGE ROAD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Gen. MAN'T</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mod. TRAN'S</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |  |   | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>PARKVILLE</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE H. KNIGHT, SR.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH M. SCHRECK</b>              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>YES WWII</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>170 03 7442</b>  | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic rectal carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>9/9</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>October 13, 1981</b> , to <b>January 24, 1981</b> , that (I) (we) last saw the deceased alive on <b>December 31, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.           |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Paul Chang, MD</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/28/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL CHANG</b>  |  | 22e. ADDRESS<br><b>5601 LOCH RAVEN BLVD.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>ENTOMBMENT</b>  | 23b. DATE<br><b>1-28-1981</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MD.</b>             |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS FUNERAL CHAPEL</b>   |  | ADDRESS<br><b>8800 HARFORD RD.</b>  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1981</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |

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— 222 —

Page 1 of 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8   |  | 1   |  | 00502   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NATALIE C. KNODE  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 18 1981  |  | 2b. HOUR<br>1:20 AM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 10, 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES ST. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>-----                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1017 Adcock Road 21093  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William W. Knode Sr.  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella R. Conway   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. U.S. CLASSIFICATION<br>(IF YES, GIVE WAR OR DATES)<br>212-26-3568<br>216-01-8332   |  | 17. INFORMANT<br>ADDRESS<br>William W. Knode Jr. 1017 Adcock Rd. 21093                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MULTIPLE Cerebrovascular Accidents</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MIN<br>MONTHS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-23</u> 19 <u>80</u> to <u>1-18</u> 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>1-18</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Peter Condoro Jr. MD</i>   |  |   |  | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>1-18-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PETER CONDRORO JR.   |  |   |  | 22e. ADDRESS<br>GBMC-6701 N. CHARLES ST.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 21, '81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Co. Maryland                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson  |  |   |  | ADDRESS<br>8521 Loch Raven Blvd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1981  |  | 25b. SIGNATURE<br><i>[Signature]</i>   |  |

UNITED STATES

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) <b>Mary Elizabeth Koerner</b>  |   |   | 2a. DATE OF DEATH<br>Month <b>Jan</b> Day <b>21</b> Year <b>1981</b>                |  | 2b. HOUR<br><b>1:15</b> P. M.                                 |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br><b>Aug 3, 1886</b>  |   | 6. AGE (In years last birthday)<br><b>94</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                             |
| 7a. BIRTHPLACE (State or foreign country)<br><b>md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Balto.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Phoenix</b>  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3531 Southside Ave. Phoenix</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House wife</b> |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>md</b>  |   | 13b. COUNTY<br><b>Balto</b>   | 13c. CITY OR TOWN<br><b>Phoenix</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              | 13e. STREET AND NUMBER<br><b>3531 Southside Ave</b>           |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Nicholas</b> Last <b>Snitker</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>First <b>ANNA</b> Middle <b>Manix</b> Last <b>Kratz</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) <b>no</b> (If yes give war or dates of service) <b>---</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218-16-5149 D</b>  |   | 17. INFORMANT<br>Address <b>Louise Koerner - Phoenix Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterio sclerotic cardio-vasc. dis</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 yr.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>cellulitis cellulitis of abdomen</b>   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                              |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1945</b> , to <b>1/21</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/20</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Elizabeth B. Sherrill Md.</b>   |   |   |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (Type) <b>ELIZABETH B. SHERRILL MD</b>   |   |   |   | 22e. ADDRESS<br><b>2106 Markton Rd, Markton Md</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |   | 23b. DATE<br><b>1/24/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Cemetery</b>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Sweet Air, Maryland</b>  |   | 24. FUNERAL DIRECTOR<br><b>J. E. Lowell Lemmon</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 22 1981</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00504

1- FOR  
STATE  
REGISTRAR

|   |                         |   |  |  |   |   |   |   |   |  |
|---|-------------------------|---|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHRISTOPHER HARRY KOLB</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>1 31 19 81</b>                                 |  |   | 2b. HOUR<br><b>M</b>  |   |   |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 28 1912 68 YRS.</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>68 YRS.</b>                                 | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br><b>2 2 19 81</b>  | 2d. HOUR<br><b>1145</b>   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>#1 Brett Court</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dept. Of Parks</b>                                |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>                 |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. CITY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Essex</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b># 1 Brett Court Apt. 202</b>                              |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Kolb</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katie Walden</b>                   |  |   | 16. SOCIAL SECURITY NO. A<br><b>217-01-6600</b>   |   |   | 17. INFORMANT<br><b>Christa Wheeler</b> 7821 Lockwood Rd. Balto., MD. 21222 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Self-inflicted gun shot wound of head</b><br>9554<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |  |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>1 31 1981</b>               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Self-inflicted gun shot wound</b> |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>1 BRETT CT. HOME</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1 BRETT CT. BALTO. MD. 21221</b>                              |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                         |   |  |  |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>J. C. Crossan O'Donovan</b>  |                         |   | TITLE (SPECIFY)<br><b>Deputy</b>   |  |   | MEDICAL EXAMINER  |   |   | DATE SIGNED<br><b>2/2/81</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>J. C. CROSSAN O'DONOVAN</b>  |                         |   | ADDRESS<br><b>2112 DUNDALK AVE. BALTO., MD. 21222</b>                                  |  |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2/5/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |                         |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |   |  |
| 7922 Wise Avenue Dundalk, MD. 21222   |                         |   |  |  |   |   |   |   |   |  |

CHARTERED BY THE  
NAVY DEPARTMENT  
NO. 1000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 81 00505   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Oscar Kopald</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 30 81  |  |   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR 3 8 1906  |  | 2b. HOUR 2 48 A.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MULTI-MEDICAL CENTER</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 13a. STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>TOWSON</b>   |  | 13e. STREET ADDRESS <b>15 TREEWAY COURT. APT 2C (21204</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS KOPALD</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MATILDA FINK</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>181-26-7990</b>  |  | 17. INFORMANT ADDRESS <b>MRS. DOROTHY KOPALD 15 TREEWAY CT. APT 2C TOWSON, MD. 21204</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1889 IMMEDIATE CAUSE (a) Bladder CA with Metastasis</b>   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastasis</b>   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>JAN 26 19 81</b> to <b>JAN 31 19 81</b> , that (1) (we) lost <b>saw the deceased alive on</b> <b>JAN 26 19 81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Howard Bond</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>1/30/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HOWARD BOND, MD.</b>  |  |  |  | 22e. ADDRESS <b>7700 YORK ROAD TOWSON, MD. 21204</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>2-1-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN ROAD</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Fritz Halberstadt</b>   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |  | 8100506                                      |                                |  |  |
|---|--|--|--|---|--|---|---|--|--|--|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |   |   |  |  |  |                                |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Nellie M. Koroneos</b>   |  |  |  |   | 2a. DATE OF DEATH<br><b>January 17, 1981</b>                                   |   |   |  |  | 2b. HOUR<br><b>M</b>                         |                                |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Jan. 20, 1914</b>  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>               |  |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2431 Woodcroft Road</b> |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                                |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Parkville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>Balt., Md. 21234<br/>2431 Woodcroft Road</b>   |  |  |                                |  |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>V.</b> LAST <b>Fitch</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>E.</b> LAST <b>Fitzpatrick</b>  |  |   |   |  |  |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-30-5160</b>   |  | 17. INFORMANT<br><b>Daughter</b>  |  |   |   | ADDRESS <b>Balt., Md. 21234<br/>2431 Woodcroft Road Margaret Linardi</b> |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>1541</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <b>Consequence of the Resection</b><br>(c) <b>Consequence of Proliferative Metastasis</b> |  |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |  |  |  |                                |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |  |                                |  |  |
| 22b. SIGNATURE<br><b>Rafael Hernandez</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  |   |   | 22c. DATE SIGNED   |  |  |                                |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Rafael Hernandez M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>7401 Osler Drive Towson, Maryland</b>                       |   |   |  |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>1-19-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>                          |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b> ADDRESS<br><b>Baltimore, Maryland</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1981</b>                            |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Rafael Hernandez</b>                    |  |  |                                |  |  |

BP

January 17, 1961

Memorandum

Re: [illegible]

TO :

FROM :

SUBJECT :

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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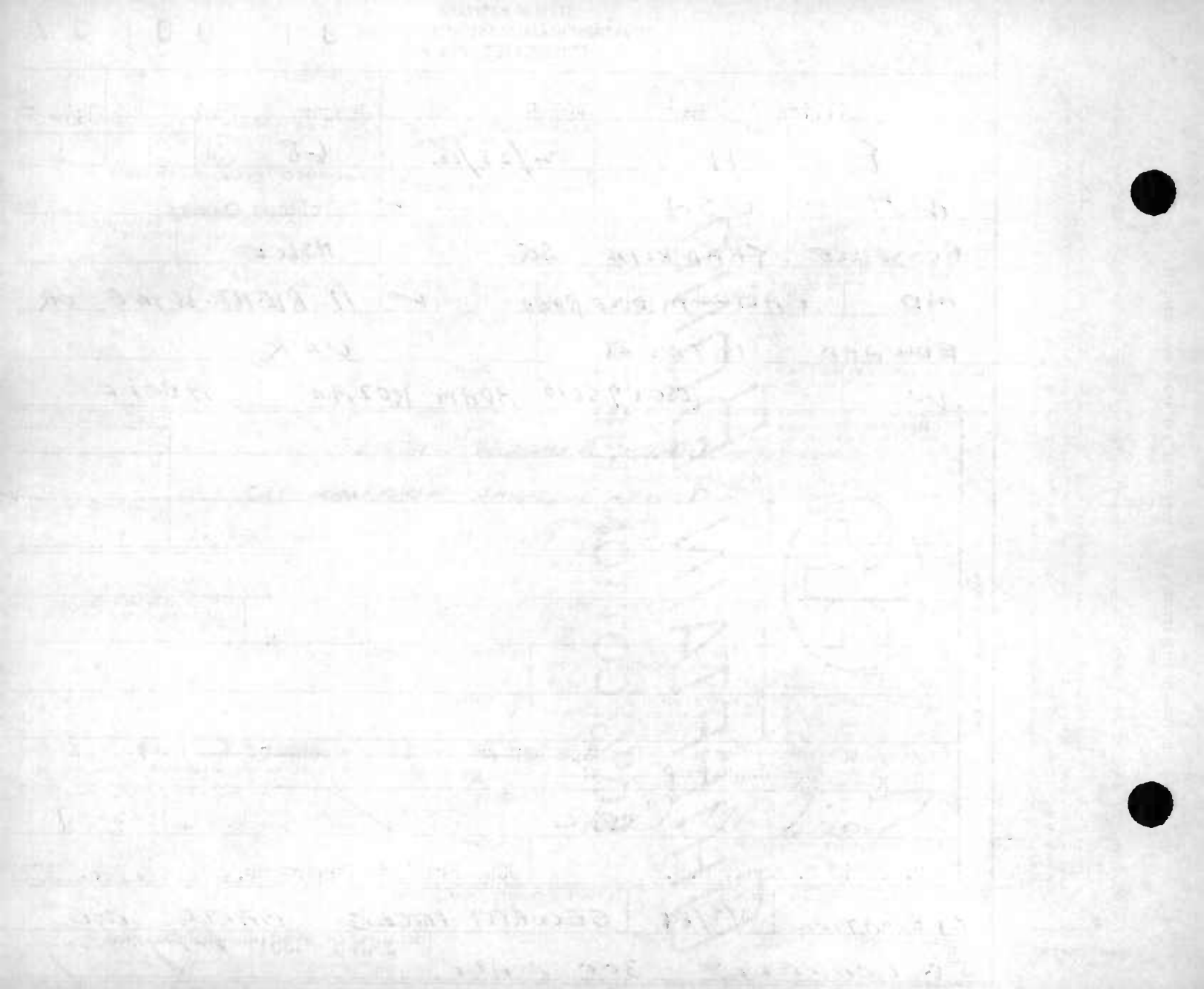
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | REG. NO. 81 00507  |   |
|--|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  | 1. DECEASED NAME (TYPE OR PRINT)           |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |
|  |  |  | Lillian May KOZAN                          |  | January 2, 1981  |   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 2b. HOUR  |
| F  |  | W  |  | 2/25/12  |  | 1:15 PM   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |
| N.Y.   |  | USA  |  |  |  | Baltimore County MD.  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| ROSSVILLE  |  | FRANKLIN SQ  |  | HSLC   |  |   |
| 13a. STATE   |  |  | 13b. COUNTY                                | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS   |
| MD.  |  |  | BALTO                                      | MIDDLE RIVER   |  | 11 RIGHT WING DR  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |  |  |   |
| EDWARD PUTNAM  |  |  | VANK                                       |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |
| NO   |  | 08095018   |  | ADAM KOZAN ABOVE   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br>4300<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE SUBDURAL HEMATOMA @</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>LEFT INTERNAL CAR. ART. ANEURYSM</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |
|  |  | 19   |  |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |
|  |  |  |  |  |  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 24, 1980, to January 2, 1981, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 2, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |  |  |  |  |   |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED  |
| David M. Cook  |  |  |  |  |  | 1-2-81  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |
| Dr. David M. Cook, M.D.  |  |  |  | 9000 Franklin Square Dr., Balto, Md., 21237  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |
| CREMATION  |  | 1/5/81   |  | SECURITY PROCESS   |  | BALTO. MD.  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DAY (MONTH) BY REGISTERED 25b. SIGNATURE  |  |   |
| J.E. CONNELLY  |  |  |  | JAN 9 1981   |  |   |
| ADDRESS  |  |  |  |  |  |   |
| 300 MALE   |  |  |  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

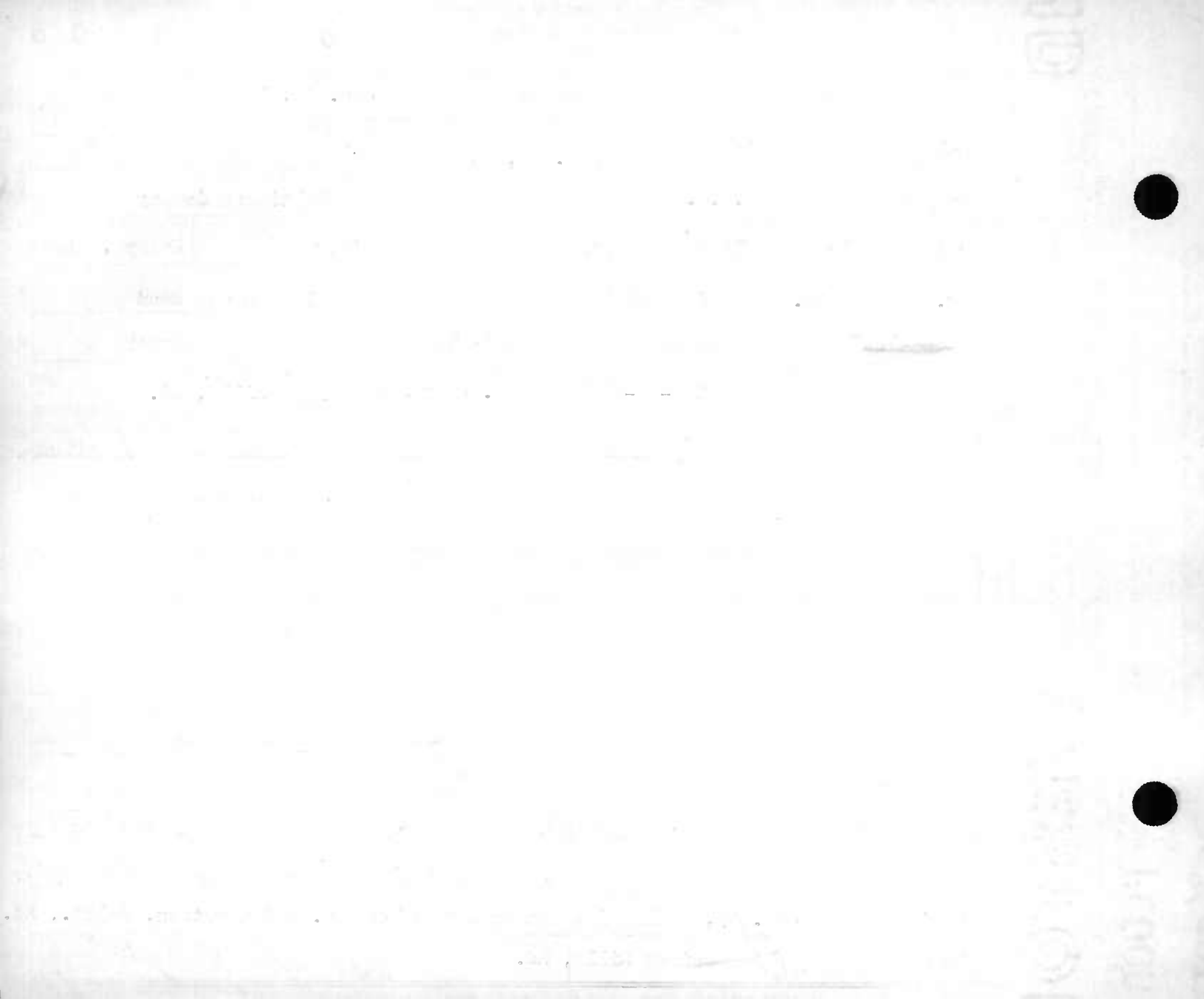
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8100508  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Donald</b>  |  | FIRST MIDDLE LAST<br><b>Krauch</b>   |  | 2a. DATE OF DEATH<br><b>Jan. 20, 1981</b>  |  | 2b. HOUR<br><b>8:30 AM</b>   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 29, 1903</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11 Wengate Road</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dairy, State</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  |  | 13b. CITY OR TOWN<br><b>Balto.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Augustus Krauch</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Chaney</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-12-6383</b>   |  | 17. INFORMANT<br><b>Mrs. Jean Long Owings Mills, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4960 Congestive Heart Failure - acute</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Years</b>  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-1</b> , 19 <b>71</b> , to <b>1-20</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1-20</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C.E. McWilliams</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1-21-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.E. McWilliams</b>  |  |  |  | 22e. ADDRESS<br><b>11904 Reisterstown Rd. Reisterstown Md. 21136</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 23, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Reisterstown Methodist Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Reisterstown, Balto., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>N. F. Schaubert</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony J. Brady</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8100509   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>YETTA KREWITSKY  |  |  |  | 2b. HOUR 10 <sup>30</sup> P.M.   |  |   |  |
| 3. SEX Female  |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 25 1997   |  | 6. AGE (IN YEARS (LAST BIRTHDAY) 83 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD  |  |
| 10. CITY OR TOWN OF DEATH Balto  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) Pikesville Nursing Home     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |
| 13a. STATE Md  |  | 13b. COUNTY Balto  |  | 13c. CITY OR TOWN Balto  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Harry Melnick   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bessie Schlichtman   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO   |  |
| 17. INFORMANT ADDRESS<br>Dorothy Goldstein 6800 Liberty Rd   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MI |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden  |  |   |  |
| 4100   |  | DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD   |  | years  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1976 to Jan 4 1981, that (I) (we) last saw the deceased alive on Jan 2 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE Joseph C. Marchitar MD  |  | DEGREE MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 1/4/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph C. Marchitar  |  | 22e. ADDRESS 3635 Old Court Rd.  |  |  |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 23b. DATE 1/5/81   |  | 23c. NAME OF CEMETERY OR CREMATORY Mt Lebanon  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Collinsdale DEL PA   |  |
| 24. FUNERAL DIRECTOR NAME Sol Levinson & Bros  |  | ADDRESS 6010 Reisterstown Rd   |  | 25a. DATE REC'D. BY REGISTRAR JAN 7 1981   |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

MEDICAL CERTIFICATION

BP



DEC

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 00510

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                            |   |  |
|--|--|---|---|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Katharina Kruschinski</i>     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1-13-81</i> |   | 2b. HOUR<br><i>11:10</i> M |   |  |
| 3. SEX<br><i>female</i>  |  | 4. RACE<br><i>white</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 5 1896</i>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>84</i> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Germany</i>                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore County General Hospital</i> |   |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>homemaker</i>            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>-</i>  |  |   |   |   |                            |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |                            |   |  |
| 13a. STATE<br><i>MD</i>  |  | 13b. CITY<br><i>Baltimore</i>   |   | 13c. CITY OR TOWN<br><i>Owings Mills</i>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><i>5 Cedarmere Road</i>   |  |   |   |   |                            |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Burnhart Boube</i>                              |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Katherina Deede</i>   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>214-30-4023</i>   |   | 17. INFORMANT<br><i>6811 Owningfield Rd.<br/>Augsburg Home Baltimore, MD. 21207</i>   |                            |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4140

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

*Acute respiratory failure, post-cardiac arrest  
arteriosclerotic heart disease with heart failure*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*days*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-5-</i> 19 <i>81</i> , to <i>1-13-</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1-13-</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Soonchul Hong</i>   |  | DEGREE   |  |  |  | 22c. DATE SIGNED<br><i>1-13-81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SOONCHUL HONG</i>  |  | 22e. ADDRESS<br><i>Baltimore County General Hospital</i>               |  |  |  |  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1/16/81</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Moreland Memorial Pk.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Parkville Baltimore MD</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Loring Byers Funeral Directors, P.A.<br/>8728 Liberty Rd., Randallstown, MD 21133</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 20 1981</i>                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. ...</i>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NOTICE

WINTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100511

REG. NO.

1- FOR  
STATE  
REGISTRAR

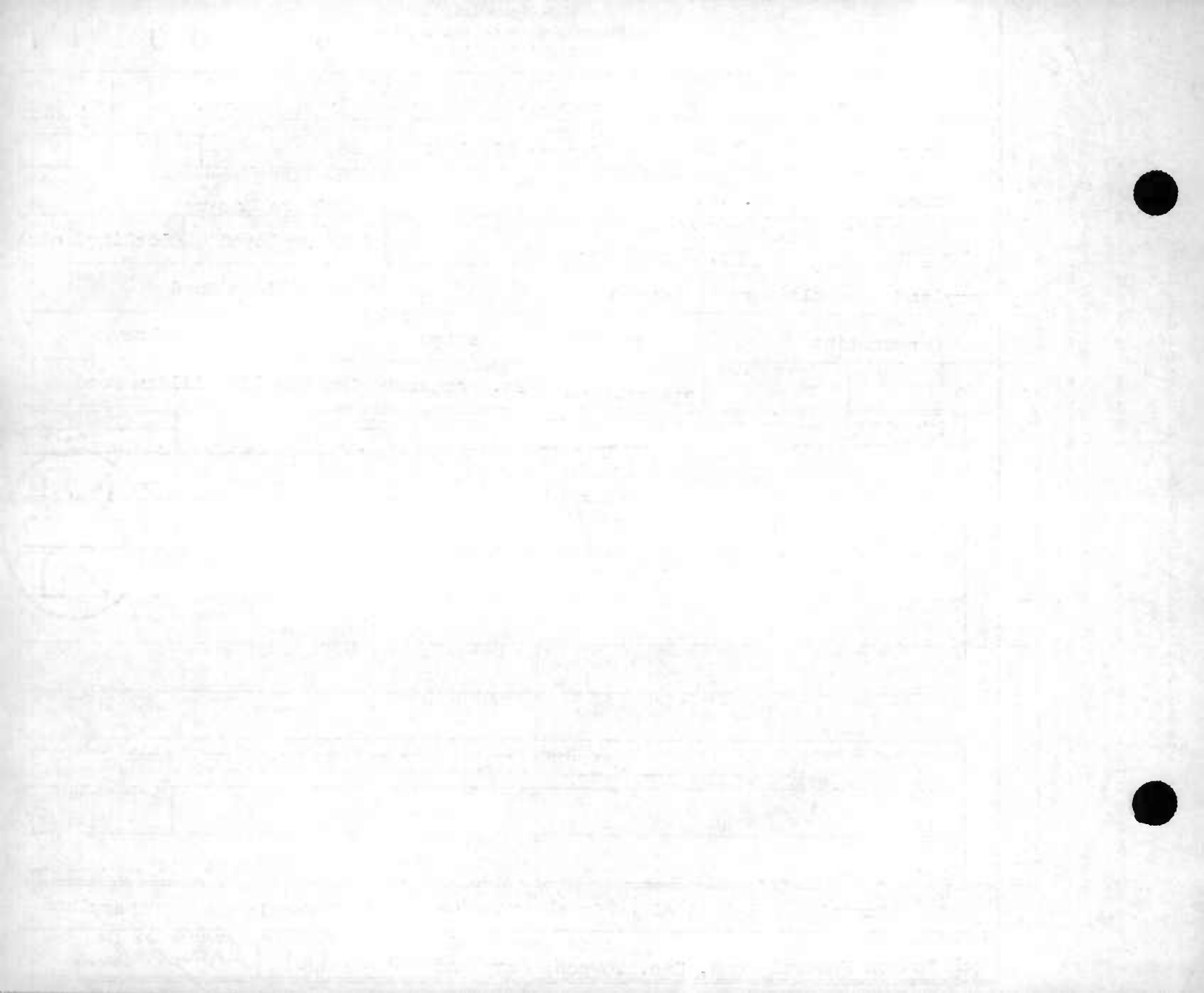
|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John G. Lambros   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 22, 1981                            |  | 2b. HOUR<br>6:15 a.m.   |
| 2. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 25, 1892   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Greece  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR NO. OF WORKING LIFE)<br>Self Employed |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Clothing & Hotel   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. CITY OR TOWN<br>Baltimore  | 13c. CITY OR TOWN<br>Towson  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Constantine Lambros  |  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE<br>Marigo unknown                            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-32-4299  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Margarete Lambros 725 Milldam Road                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4241 Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aortic stenosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic Stenosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>73 years</u>   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u>                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Pneumonia &amp; Bronchitis</u>   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 6, 1981</u> to <u>Jan. 22, 1981</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Jan. 22, 1981</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><u>Luke Terry</u>  |  | DEGREE  |   | 22c. DATE SIGNED<br><u>1/22/81</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Luke Terry, M.D.  |  | 22e. ADDRESS<br>9055 Chevrolet Dr. Ellicott City, Md. 21043   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-24-1981  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greek Orthodox                                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Woodlawn Maryland  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson; Maryland   |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>History McCreedy</u>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | 8100512<br>REG. NO.   |  |
|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS EDWARD LANDEFELD, SR.</b>  |  |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>29</b> YEAR <b>81</b>                                |  | 2b. HOUR <b>6:25</b> AM   |  |
| 3 SEX <b>MALE</b>  | 4 RACE <b>White</b>  | 5 DATE OF BIRTH MONTH <b>02</b> DAY <b>25</b> YEAR <b>04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS                                  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.               |   |  |
| 10 CITY OR TOWN OF DEATH <b>TOWSON Hts.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Northwood Medical Nursing Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fork Lift Operator</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>9502 Perry Hall Blvd.</b>  |  |
| 14. FATHER'S NAME FIRST <b>Louis</b> MIDDLE <b>H.</b> LAST <b>Landefeld</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Minnie</b> MIDDLE <b>-</b> LAST <b>(unknown)</b>           |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |  | 17. INFORMANT <b>George E. Landefeld, son,</b> ADDRESS <b>13103 Fork Road, 21013</b>         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal cell carcinoma</b><br><b>1890</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>undergrad metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/29</b> , 19 <b>81</b> , to <b>1/29</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                 |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Benjamin K. Yorkoff, M.D.</b>  |  | DEGREE   |  | 22c. DATE SIGNED <b>1/30/81</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Benjamin Yorkoff, M.D.</b>  |  | 22e. ADDRESS <b>7401 Osler Suite 210</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  | 23b. DATE <b>1/31/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE                          | 25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1981</b> 25b. REGISTRAR'S SIGNATURE     |   |  |
| 24. FUNERAL DIRECTOR <b>Schlimmek Funeral Home, Inc.</b>   |  | 24b. ADDRESS <b>9705 Belair Road Balto., Md. 21236</b>   |  |  |   |  |

BP

1860

1860



*[Faint, illegible handwriting on lined paper]*

*[Faint, illegible handwriting on lined paper]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8100513  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR                                     |  |
| LOUIS V. LANG  |  |  |  |  |  |  |  | January 16, 1981   |  | 12:47 A.M.                                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                              |  |
| Male   |  | White  |  | October 19, 1890   |  | 90   |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore County MD  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (IF NOT WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Towson   |  | St. Joseph's Hospital  |  |  |  |  |  | Butcher  |  | Grocery                                      |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| Maryland   |  | Baltimore  |  | Timonium   |  |  |  | 139 Hollow Brook Road  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  |
| John G. Lang   |  | Caroline Pfeiffer  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |  |  |
| No   |  | 215-05-6991  |  | Mr. Louis W. Lang 139 Hollow Brook Road  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | one week                                     |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 4340 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  | 12-22-80                                     |  |
| (b) <u>Cerebral thrombosis</u>   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | 30 years                                     |  |
| (c) <u>Arteriosclerosis</u>  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 20, 1965</u> , to <u>January 16, 1981</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>Jan. 3, 1981</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | 22c. ADDRESS   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE SIGNED   |  |  |  |
| <i>Donald O. Wood</i>  |  | York Road and Greenmeadow Drive  |  | Donald O. Wood, M.D.   |  |  |  | 1/16/81  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | 23e. COUNTY STATE  |  |  |  |
| Burial   |  | 1-19-1981  |  | Loudon Park  |  | Baltimore  |  | Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Ruck Towson Funeral Home, Inc.   |  | 1050 York Road   |  | JAN 19 1981  |  | <i>Erin M. M...</i>  |  |  |  |  |  |
| Towson, Maryland   |  |  |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

RECEIVED

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100514

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |   |  |
|---|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES</b> <sup>FIRST</sup> <b>Melvin</b> <sup>MIDDLE</sup> <b>LAUPHEIMER</b> <sup>LAST</sup>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/29/81</b> <b>1</b> <b>29</b> <b>81</b> |   |   | 2b. HOUR:05<br>2-05 AM   |   |   |  |
| 3. SEX<br><b>M</b> Male   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12</b> <b>28</b> <b>06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> <b>74</b> YRS.                          |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balt. Co. General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>City Gov't.</b>         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3630 Yenar Lane 21207</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard Laupheimer</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sara Frock</b>                              |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-09-8921</b>                                     |   | 17. INFORMANT ADDRESS<br><b>Mrs. Margaret E. Reed Same as # 13</b>                              |  |   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**1539**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1/16/81</b> , 19 <b>81</b> , to <b>1/29/81</b> , 19 <b>81</b> , that (I) (we) last<br>saw the deceased alive on <b>1/29/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>John M.</b>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>1/29/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S R INI VITS</b>  |  |  |  | 22e. ADDRESS<br><b>Baltimore County Gen Hosp.</b>                              |  |   |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>1/29/81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Baltimore Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MacNabb Funeral Home</b>   |  |                             |  | ADDRESS<br><b>Catonsville, Md.</b>                            |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1981</b>                                |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. H. H.</b>          |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified.

UNITED STATES

DEPARTMENT OF AGRICULTURE

1914

1914

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8100515<br>REG. NO.   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MIRIAM (nmn) LAYNOR</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 16, '81</b>   |  | 2b. HOUR<br>M<br><b>M</b>   |   |
| SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 8, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b><br>YRS. MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL NAME AND ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Emp.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Monument co.</b>  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. CITY OR TOWN<br><b>A.A.</b>  |  | 13c. STREET ADDRESS<br><b>200 Crain Highway, S.W.</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Norton</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Ijams</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |  | 17. INFORMANT (Son) ADDRESS<br><b>Mr. Mark N. Schatz, Glen Burnie, Md.</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629 CARDIORESPIRATORY ARREST</b><br>IMMEDIATE CAUSE (a)<br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CANCER OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-31</b> <b>80</b> to <b>1-16</b> <b>81</b> , that (I) (we) last<br>saw the deceased alive on <b>1-16</b> <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (and I did not) view the body after death.  |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><i>Pollacchi Luis</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1-16-81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Pollacchi Luis</b>  |  |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>19 JAN. 81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A., MD.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME <i>Singleton</i> ADDRESS <b>Glen Burnie, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>P. J. Schatz</i>   |   |



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WHITE

FILE

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100-100000-100000

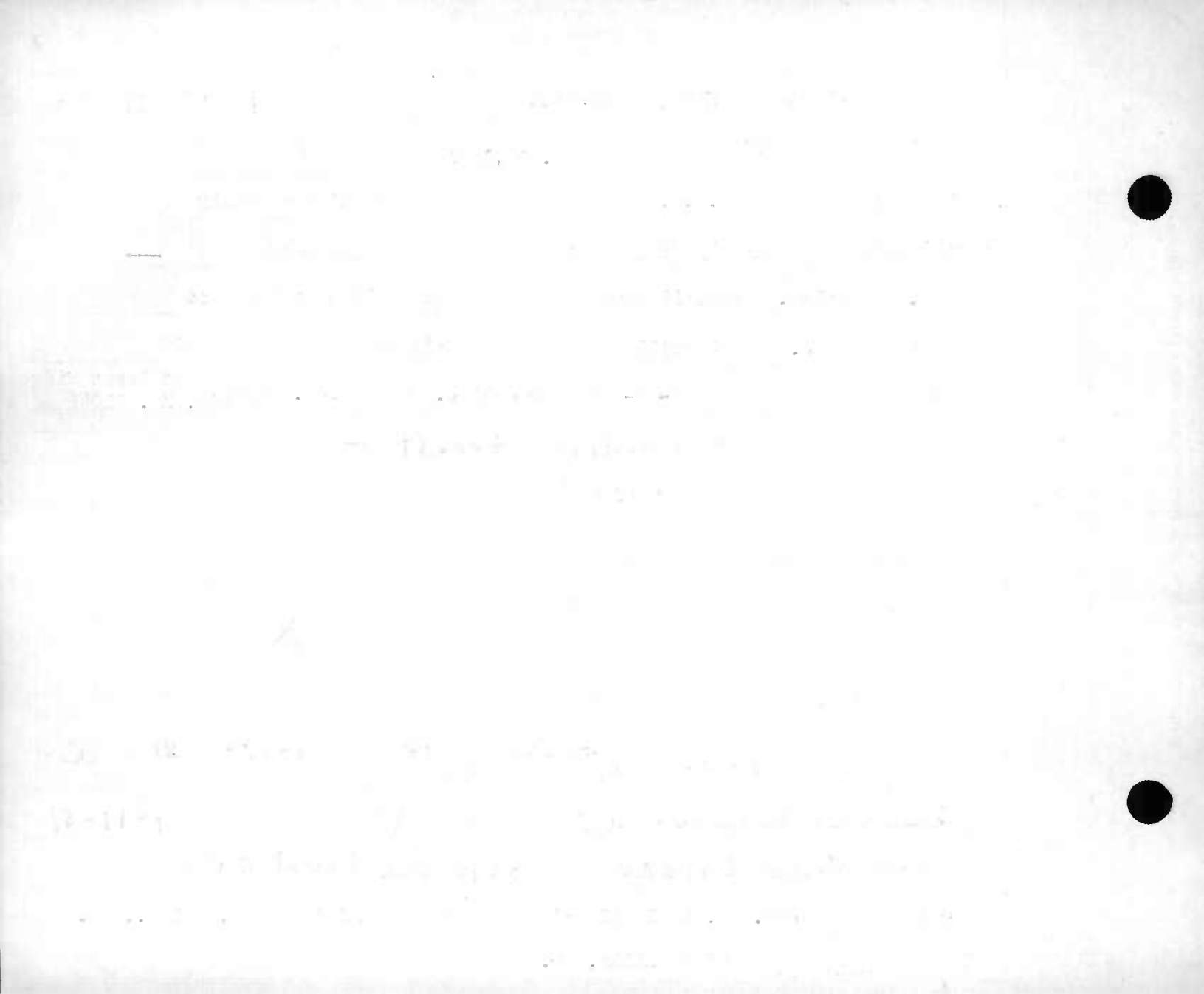
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8100516  |  | REG. NO.   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Calista   |  | Maude  |  | Leavitt  |  |   |  | 1-17-81   |  | 8 a M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Female  |  | White  |  | Nov. 28, 1881  |  | 99 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| New Hampshire   |  | U.S.A.   |  |  |  | Baltimore County MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| Randallstown  |  | Chapel Hill Nursing Home   |  | Housewife  |  |   |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS                          |  |
| Md.   |  | Balto.   |  | Randallstown   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 11 Sheraton Road                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS                                      |  |
| Thomas J. Morrill   |  | Calista Smith  |  | No   |  | 003-05-2411   |  | Russell J. Channer, Jr.   |  | 9505 Sweet Grass Ridge Columbia, Md. 21046   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Cardiac Arrest -  |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD   |  |  |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-22-1975, to 1-17-1981, that (I/we) last saw the deceased alive on 1-17-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |   |  | 22c. DATE SIGNED  |  |  |  |
| Cesar Valle Caveno M.D.   |  |  |  |  |  |   |  | 1-17-81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |  |  |
| CESAR VALLE CAVERO  |  | 5310 old Court Rd.   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| Burial  |  | Jan. 19, 1981  |  | All Saints Cemetery  |  | Reisterstown, Balto., Md.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME   |  | ADDRESS  |  | 25a. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| H. G. Eckhardt  |  | Owings Mills, Md.  |  |  |  |   |  |   |  |  |  |

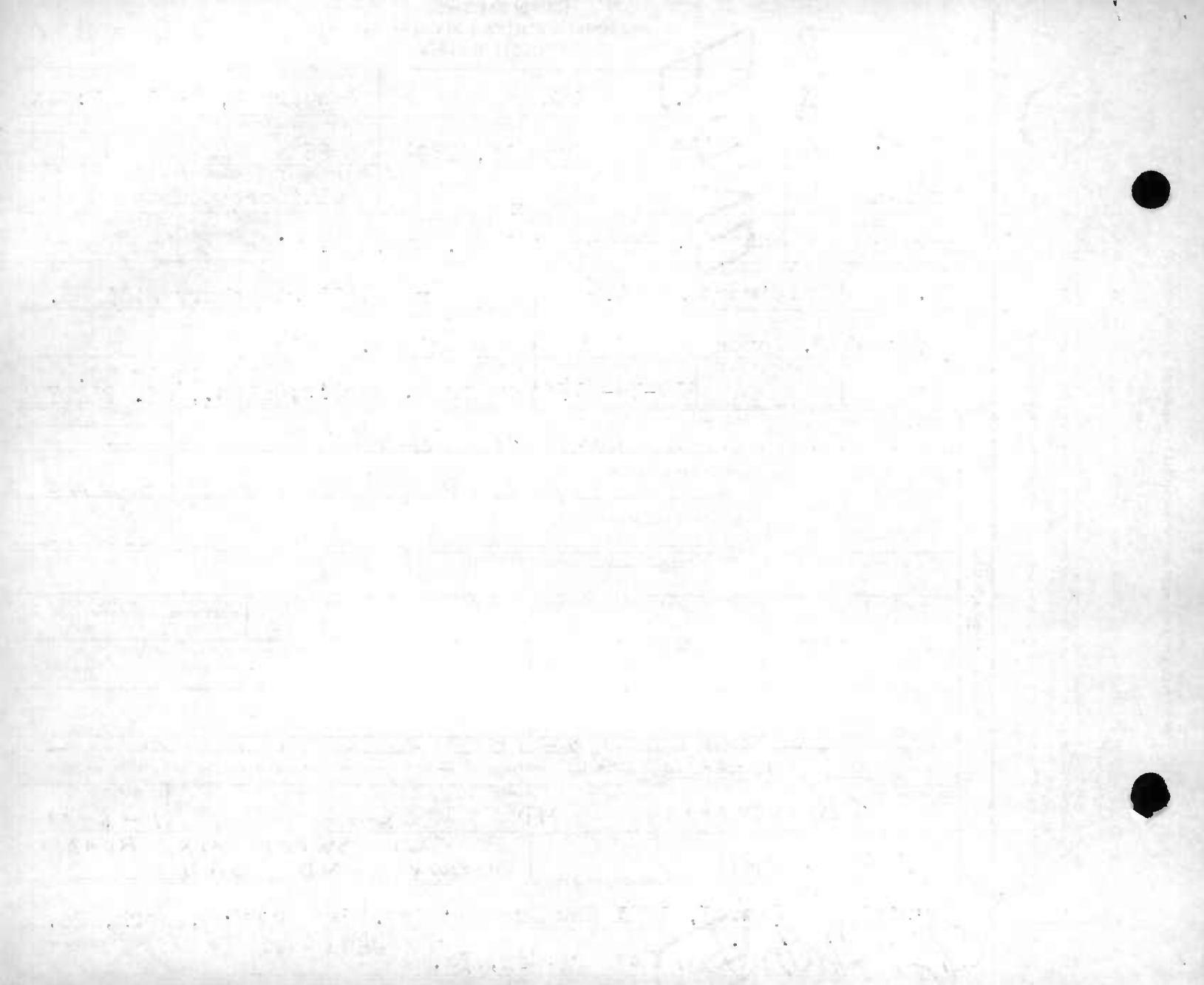


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IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                           |   |   |  |  |  |   | 8100517  |                  |                              |  |   |  |  |  |
|---|--|--|---------------------------|---|---|--|--|--|---|--|------------------|------------------------------|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |                           |   |   |  |  |  |   | REG. NO.   |                  |                              |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>LIDA B. LEE   |  |  |                           |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 1, 1981   |  |  |  |   | 2b. HOUR<br>7:00A <sub>M</sub>   |                  |                              |  |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |                           | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 14, 1894  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | IF UNDER 24 HRS. |                              |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |                           |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |  |                  |                              |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Monkton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4401 Stansbury Mill Rd. |                           |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife     |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |                  |                              |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |  |                           |   |   |  |  |  |   | 13b. COUNTY<br>Baltimore   |                  | 13c. CITY OR TOWN<br>Monkton |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>4401 Stansbury Mill Rd. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Samuel J. Jones  |  |  |                           |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maggie A. Davis   |  |  |  |   |  |                  |                              |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  |                           |   | 16b. SOCIAL SECURITY NO.<br>214-74-2175   |  | 17. INFORMANT ADDRESS<br>Evelyn L. Burlin, Balto., Md. 21207                   |  |   |  |                  |                              |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                  |  |  |                           |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 years  |                  |                              |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                           |   |   |  |  |  |   |  |                  |                              |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |                              |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |                  |                              |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |                  |                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-15</u> , 19 <u>80</u> , to <u>1-1</u> , 19 <u>81</u> , that (I) <del>was</del> lost saw the deceased alive on <u>12-22</u> , 19 <u>80</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <u>did not</u> view the body after death. |  |  |                           |   |   |  |  |  |   |  |                  |                              |  |   |  |  |  |
| 22b. SIGNATURE<br><u>J.R. Norris</u>  |  |  |                           | DEGREE<br>MD.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |  | 22c. DATE SIGNED<br><u>1-6-81</u>         |  |                  |                              |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. R. NORRIS   |  |  |                           | 22e. ADDRESS<br><u>3421 SWEET AIR ROAD</u><br><u>PHOENIX MD 21131</u>   |   |  |  |  |   |  |                  |                              |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Jan. 3, 1981 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Freedom Cem.  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>New Freedom, York, Pa.                    |   |  |                  |                              |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>St. Hartenstein</u>  |  |  |                           | ADDRESS<br>New Freedom, Pa.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1981 |  |  | 25b. REGISTRAR'S SIGNATURE                |  |                  |                              |  |   |  |  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |   | 8 1 0 0 5 1 8   |   |
|--|---|---|---|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   |   |   | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Benjamin J. LEGG</i>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 4 81</i>                                |   | 2b. HOUR<br><i>5:11 AM</i>                                    |
| 3. SEX<br><i>male</i>  | 4. RACE<br><i>WHITE</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6/17/09</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>W. VA.</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO County</i> MD.                                 |   |
| 10. CITY OR TOWN OF DEATH<br><i>ROSSVILLE BALTIMORE</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>FRANKLIN SQ. Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>AIRCRAFT</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. STATE<br><i>MD.</i>   |   | 13b. COUNTY<br><i>BALTO</i>   | 13c. CITY OR TOWN<br><i>ESSEX</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>ALBERT LEGG</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>UDELLA VNK</i>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>VNK</i>   |   | 16b. SOCIAL SECURITY NO.<br><i>235 18 3610</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>OLIVE LEGG ABOVE</i>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i><br><i>1629</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CARCINOMA of Lung</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>December 17, 1980</i> to <i>January 4, 1981</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>January 4, 1981</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><i>M. Khan M.D.</i> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |   |   | 22c. DATE SIGNED<br><i>Jan. 4, 1981</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>M. Khan M.D.</i>   |   |   |   | 22e. ADDRESS<br><i>9000 Franklin Square Drive 21237</i>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |   | 23b. DATE<br><i>1/7/81</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MORELANDS</i>                              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTO MD</i> |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>J.G. CONNELLY</i>   |   | ADDRESS<br><i>300 MACE AVE</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 9 1981</i>  |   |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |

(5)

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

1. Name of the plant or animal: *...*  
2. Name of the collector: *...*  
3. Date of collection: *...*  
4. Locality: *...*  
5. Description of the specimen: *...*  
6. Remarks: *...*



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                           |  | 8100519                                      |     |  |          |                  |  |
|---|--|--|--|--|--|---|--|---------------------------|--|--|-----|--|----------|------------------|--|
| FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH         |  | MONTH  | DAY | YEAR   | 2b. HOUR |                  |  |
| Willam Raymond  |  | Lenderking   |  |  |  |   |  | 1/8/81                    |  |  |     |  | 6 AM     |                  |  |
| SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. UNDER 1 YEAR           |  | 8. UNDER 24 HRS.                             |     |  |          |                  |  |
| Male  |  | White  |  | 7 19 97  |  | 83  |  | YRS                       |  | MONTHS                                       |     | DAYS   |          |                  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                           |  |  |     |  |          |                  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore County  |  | MD.                       |  |  |     |  |          |                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                           |  |  |     |  |          |                  |  |
| Towson  |  | Major Care Luster  |  | Vice President   |  | Lily Tulip Cup  |  |                           |  |  |     |  |          |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS       |  |  |     |  |          |                  |  |
| Maryland  |  | Baltimore  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 500 W. University Parkway |  |  |     |  |          |                  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| William Daniel  |  | Maline   |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS   |  |                           |  |  |     |  |          |                  |  |
| Yes   |  | WW II  |  | Mrs. Joan Dorey  |  | 100 Greenridge Road   |  |                           |  |  |     |  |          |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |  |          |                  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| IMMEDIATE CAUSE (a) Cardiac arrest  |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| 4292  |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| (b) Atherosclerotic Cardiovascular Disease  |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| (c) of 5 years duration   |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                           |  |  |     |  |          |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                           |  |  |     |  |          |                  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                           |  |  |     |  |          |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  |   |  |                           |  |  |     |  |          |                  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]  |  |   |  |                           |  |  |     |  |          |                  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |                           |  |  |     |  |          |                  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN  |  | COUNTY                    |  | STATE  |     |  |          |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                           |  | 22b. SIGNATURE                               |     | DEGREE   |          | 22c. DATE SIGNED |  |
|   |  |  |  |  |  |   |  |                           |  | Walter T. Kees MD                            |     | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |          |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |                           |  | 22e. ADDRESS                                 |     |  |          |                  |  |
| WALTER T. KEES  |  |  |  |  |  |   |  |                           |  | Monken MD 21111                              |     |  |          |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                           |  |  |     |  |          |                  |  |
| Cremation   |  | 1/9/81   |  | Greenmount Crematory   |  | Baltimore Maryland  |  |                           |  |  |     |  |          |                  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |   |  |                           |  | 25a. DATE REC'D. BY REGISTRAR                |     | 25b. REGISTRAR'S SIGNATURE   |          |                  |  |
| Ruck Towson Funeral Home, Inc., 1050 York Road  |  |  |  |  |  |   |  |                           |  | JAN 9 1981                                   |     | [Signature]  |          |                  |  |

6.1

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |  |  |   |  |  |
|--|--|---|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>JACOB ISAAC LERNER</b>   |  |   |   |  | 2a. DATE OF DEATH MONTH <b>1-3-81</b> DAY <b>10</b> YEAR <b>81</b>                     |  |  |   |  |  |
| 3 SEX <b>MALE</b>  |  | 4 RACE <b>CAUC</b>  |   | 5 DATE OF BIRTH MONTH <b>06-05-02</b> DAY <b>06</b> YEAR <b>02</b>             |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>                |  |  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>            |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>SOCIAL SEC.</b>  |  |  |
| 13a. STATE <b>MARYLAND</b>   |  |   | 13b. COUNTY <b>BALTO.</b>                   |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS <b>8225 BRATTLE RD. #21208</b> |  |
| 14 FATHER'S NAME FIRST <b>AARON</b> MIDDLE <b>LERNER</b> LAST <b>UNKNOWN</b>   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>SARAH</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO. <b>219-10-0022</b> |  | 17 INFORMANT <b>MR. JOSEPH LERNER</b> ADDRESS <b>8225 BRATTLE RD. BALTO., MD 21208</b> |  |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>4100</b> |  |   |   |  |  |  |  |   |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4100</b>  |  |   |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION <b>NA</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-3-81</b> , to <b>1-3-81</b> , that (I) (we) lost the deceased alive on <b>1-3-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                  |  |   |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |  | 22c. DATE SIGNED <b>1-3-81</b>   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>INDRA V. REDDY</b>  |  |   |   |  | 22e. ADDRESS <b>BALTO. COUNTY GEN HOSPITAL RANDALLSTOWN, MD 21133</b>                  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>JAN. 5, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>FRIEDEL MARYLAND LODGE</b>               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>          |  |   |  |  |
| 24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |   |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00521

1- FOR  
STATE  
REGISTRAR

|  |                         |   |   |   |   |   |   |  |
|--|-------------------------|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thomas James Levy</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 30 1981</b> |   |   | 2b. HOUR<br>M<br><b>11:46</b>   |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-24-21</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>59</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 30 1981</b>                      |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Firefighter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto.CO</b> |
| 13a. COUNTY<br><b>Maryland</b>   |                         |   | 13b. CITY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Rosedale</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>946 Rosedale Avenue</b>                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Levy</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Michel</b>  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216183705</b>  |   | 17. INFORMANT ADDRESS<br><b>Marian P. Levy 946 Rosedale Ave.</b>                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                         |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         |   | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>  |   |   | DATE SIGNED<br><b>1/31/81</b>   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn Street</b>   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>2-3-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>                              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John J. [Signature]</b>   |                         |   | ADDRESS<br><b>1211 Chesaco Ave.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1981</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>     |

NS-10-5

Page 1

1. Officer [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

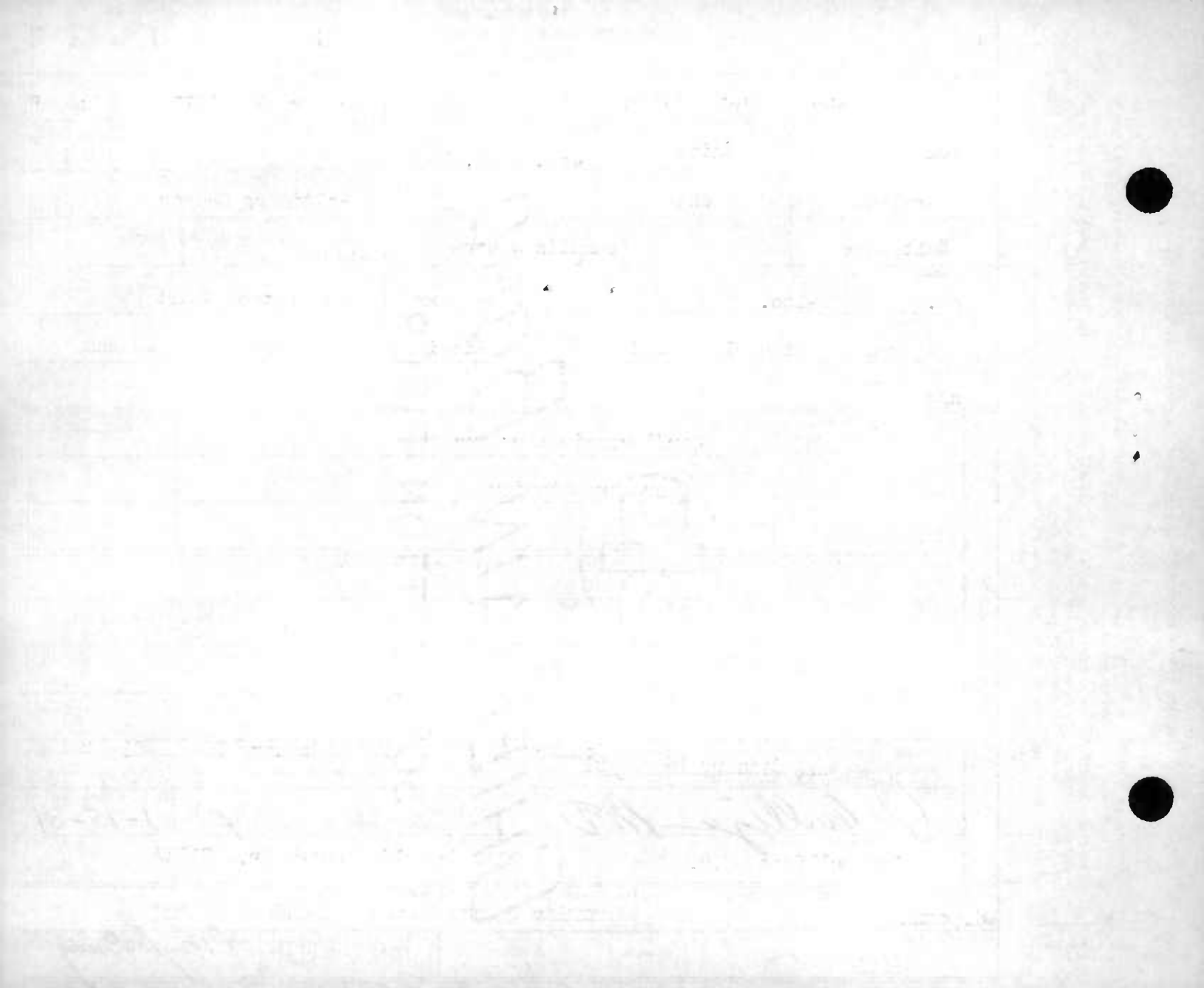
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |                                   | 8100522  |  |
|--|--|--|--|---|--|--|--|--|-----------------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |                                   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Baby Girl LEWIS   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 15, 1981                        |  |  | 2b. HOUR<br>5:00 P.M.             |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 15, 1981   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br>4                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>4  |                                   | IF UNDER 74 HRS.<br>HOURS MIN.<br>4  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Infant     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.  |  |  |  |   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET ADDRESS<br>41C Dutrow Court  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Steven Michael Lewis   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Vicki Lynn Skeens  |  |  |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>n/a  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>7650<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Severe prematurity<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                                   |  |  |
| 22a. I certify that (this hospital) attended the deceased from January 15, 1981, to January 15, 1981 that (we) lost saw the deceased alive on January 15, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |                                   |  |  |
| 22b. SIGNATURE<br>Peg Mulligan M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>1-15-81  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Peg Mulligan M.D.   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Disposal   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Franklin Square Hosp                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto Md                                   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>NONE   |  |  |  | ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1981   |                                   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  | 8100523<br>REG. NO.  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>GEORGE NEEDHAN LEWIS, Jr.   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 1st, 1981                          |  |  | 2b. HOUR<br>10:15A <sub>M</sub>                                |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH MONTH DAY YEAR<br>December 13, 1906  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                     |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City CO MD.                 |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6003 Huntridge Rd. |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>State Roads |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Traffic                   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Balto City  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Geo N. Lewis  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen Llewellyn                  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>220-36-8080  |  | 17 INFORMANT ADDRESS<br>Mrs. Erana M. Lewis-6003 Huntridge Rd.                       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a):<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Myocardial Infarction<br>(c) Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Hypertension, Diabetes Mellitus<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hrs.<br>20-30 min<br>20-30 min |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>1/1/81   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  |  | 21b. TIME OF DEATH HOUR A.M. MONTH DAY YEAR<br>10:15 AM 1/1/81              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Home |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>9178 1/1/81                  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive at above (If (we) did) (did not) see the body after death.   |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Ronald L. Broadwater, Sr. M.D.   |  |  |   |  | 22c. DATE SIGNED<br>1/2/81   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  | 22e. ADDRESS<br>2428 Eastridge Rd. Timonium                                    |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1/3/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Memorial                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto Co.                                 |  |  |  |
| 24 FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home-6500 York Rd. 21212   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1981                                    |  | 25b. HOSPITAL SIGNATURE  |  |  |  |

Handwritten notes and stamps at the top of the page, including dates and administrative markings.

Handwritten notes in the middle section, possibly a list or a set of instructions.

Large handwritten signature or name in the lower middle section, with additional notes and dates.

Handwritten notes and stamps at the bottom of the page, including dates and administrative markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   | 8 1 0 0 5 2 4   |  |   |  |                                   |                           |  |
|--|--|--|--|--|--|---|--|--|---|---|--|---|--|-----------------------------------|---------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.   |  |  |   |  |  |   |   |  |   |  |                                   |                           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>NORMAN  |  |  | MIDDLE<br>LEWIS   |  |  | LAST<br>LEWIS   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 31, 1981 |  |                                   | 2b. HOUR<br>P. M.<br>6:40 |  |
| 3. SEX<br>MALE   |  |  | 4. RACE<br>WHITE   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT. 20, 1911   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.         |  | 8. IF UNDER 24 HRS.<br>HOURS MIN. |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |   |  |   |  |                                   |                           |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MANOR CARE NURSING HOME |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MERCHANT  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL   |   |  |   |  |                                   |                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |   |  |  |   | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13b. STREET ADDRESS<br>6416 ELRAY DR., APT. D 21209     |  |                                   |                           |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |  |   |   |  |   |  |                                   |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL LEWIS   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ESTHER CARP   |  |  |   |  |  |   |   |  |   |  |                                   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-01-1411   |  |  | 17. INFORMANT<br>ADDRESS<br>MRS. HILDA LEWIS<br>6416 ELRAY DR., APT. D #21209   |  |  |   |   |  |   |  |                                   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Hypocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ascu</u>   |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |                                   |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |   |   |  |   |  |                                   |                           |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |                                   |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |  |   |  |                                   |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |   |  |                                   |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>60</u> , to <u>2/1/81</u> , 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/1/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |  |   |   |  |   |  |                                   |                           |  |
| 22b. SIGNATURE<br><u>W.C. FSON</u>   |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br>2/2/81  |   |  |   |  |                                   |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W.C. FSON   |  |  | 22e. ADDRESS<br>350 V. de. Rogers  |  |  |   |  |  |   |   |  |   |  |                                   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>FEB. 2, 1981  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BNAI ISRAEL   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |   |  |   |  |                                   |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.   |  |  | ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1981   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>  |   |  |   |  |                                   |                           |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | REG. NO. 8100525   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>R. <del>Winglorax</del> Virginia Leys</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 10, 1981</b>                        |  | 2b. HOUR<br><b>3:30 AM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 16, 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>417 Brook Road</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Towson</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |  |  | 13e. STREET ADDRESS<br><b>417 Brook Road</b>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Allie Mc Callister</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rachel Wheeler</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>084-12-1305B</b>  |  | 17. INFORMANT<br><b>David S. Leys</b>   |  |   |  | ADDRESS<br><b>Same as #13.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1820</b> IMMEDIATE CAUSE (a) <b>Metastatic endometrial carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>26 mo</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>Nov 28, 1978</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Endometrial Carcinoma</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this physician) attended the deceased from <b>MARCH 1959</b> to <b>January 10, 1981</b> , that (I) (we) lost saw the deceased alive on <b>Sept 12, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Marc I. Leavey MD</b>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>10 Jan 81</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC I. LEAVEY MD</b>  |  |  |  | 22e. ADDRESS<br><b>Osler Drive Suite 315 Towson, Md. 21204</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1-12-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>              |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  |  |  | ADDRESS<br><b>1050 York Road Towson, Md. 21204</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1981</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

MEDICAL CERTIFICATION

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 0 0 5 2 6<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IDA S. LIBOWITZ</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>JAN 26 1981</b>  |  | 2b. HOUR<br><b>8:25 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>AUG. 18, 1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MILFORD MANOR NURSING HOME</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13c. STREET ADDRESS<br><b>3500 DENNY LN RD. #21215</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NOAH SHERRY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH MILDRED HEKELMAN</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-7794</b>   |  | 17. INFORMANT<br><b>MR. NORMAN LIBOWITZ</b>   |  | 17b. ADDRESS<br><b>3504 ARBORWOOD CT. BALTO., MD 21208</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cerebrovascular Accid.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis - multibac</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b><br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>acute 2 yrs</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Urinary tract infection</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1-26-81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Urinary tract infection</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>approx 73</b> , 19 <b>73</b> , to <b>1-26</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>JAN 22</b> , 19 <b>1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) did not view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>H. Gerald Oster</b> MD  |  |  |  | 22c. DATE SIGNED<br><b>1-26-81</b>  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Gerald Oster</b>  |  |  |  | 22f. ADDRESS<br><b>3635 Old Court Rd.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/28/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |   |  |   | 8100527                                      |  |
|--|--|---|--|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |  |   |  |   | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILDRED LINCOLN</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-26-81</b>                 |  |   | 2b. HOUR<br><b>12:25</b> M   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 27 06</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>12 25</b>  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>St. Leonard</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>  |  |   |  |   | 13c. CITY OR TOWN<br><b>Calvert Co.</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Box 148A St. Leonard, Md. 20685</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN Bell</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda Baier</b> |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-16-3659</b>  |  | 17. INFORMANT ADDRESS<br><b>Maryland 20685</b><br><b>Dorothy M. Edmonds Box 148A, St. Leonard,</b>  |   |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ARTERIO-SCLEROTIC HEART DISEASES - DIABETES MELLITUS</b>  |  |   |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19 81</b>        |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-21-81</b> to <b>1-26-81</b> , that (I) (we) last saw the deceased alive on <b>1-26-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Orlando B. Conanan, MD.</b>   |  |   |  |   | DEGREE<br><b>MD.</b>  |  |   |  |   | 22c. DATE SIGNED<br><b>1-26-81</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ORLANDO B. CONANAN, MD.</b>  |  |   |  |   | 22e. ADDRESS<br><b>BGGH, RANDOLPHSTOWN Md. 21133</b>                  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial.</b>   |  |   | 23b. DATE<br><b>1/28/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>     |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1981</b>                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy M. Edmonds</b>   |  |   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 6 0 5 2 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Robert Alfred Linsebigler</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 3, 1981</b>                          |   | 2b. HOUR<br>M   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 26, 1928</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                            |   |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1413 Stengel Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel</b>   |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Dundalk</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfred Linsebigler</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gretta Piper</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII &amp; Korea 163-22-9025</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. I. Jean Linsebigler Same as #13.</b>                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the Colon</b>  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>1 year</b><br><b>2 years</b>                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/4</b> , 19 <b>80</b> , to <b>1/3</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>12/18</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE<br><b>George J. Richards, Jr. - MD</b>   |   | 22c. DEGREE<br><b>MD</b>  |  | 22d. DATE SIGNED<br><b>1/5/81</b>   |   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George J. Richards, Jr., M.D.</b>   |   | 22f. ADDRESS<br><b>G.B.M.C. Towson, Maryland 21204</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Jan. 6, 1981</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Overlea Baltimore, Md.</b>                     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda Ruck Funeral Home of Dundalk, Inc. Md. 21222</b>  |   | 24b. ADDRESS<br><b>7922 Wise Ave. Dundalk,</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1981</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 8100529                |  |
|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARK</b>  |  |  | FIRST <b>Mark</b> MIDDLE <b>Steven</b> LAST <b>Litfin</b>              |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/12/81</b>                                 |  |  | 2b. HOUR<br><b>11:00 PM</b>                              |                                 |  |
| 3 SEX <b>Male</b>  |  | 4 RACE <b>Caucasian</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 22, 1959</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>21</b> YRS.                                   |  | 7a. IF UNDER 1 YEAR MONTHS DAYS  |  | 7b. IF UNDER 72 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                 |  |  |  |                                 |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balt. Co. General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cashier</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b>   |  |                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Chadwick</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>7208 Chamberlain Rd. 21207</b> |                                 |  |
| 14 FATHER'S NAME<br>FIRST <b>Jerry</b> MIDDLE <b>S.</b> LAST <b>Litfin</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Kathleen</b> MIDDLE <b>A.</b> LAST <b>Wilkinson</b>  |  |  |  |  |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  | 17 INFORMANT ADDRESS<br><b>Mrs. Kathleen A. Wilkinson Same as 13</b> |  |  |  |  |                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>COMA</b><br><b>2500</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CEREBROVASCULAR ACCIDENT</b><br>(c) <b>DIABETES</b>  |  |  |  |  |  |  |  |  |  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>PNEUMOTHORAX</b>   |  |  |  |  |  |  |  |  |  |                                 |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |  |  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |  |  |                                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                 |  |
| 22b. SIGNATURE<br><b>Haffer</b>  |  |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/12/81</b>                       |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFFER 17 SYED M.D.</b>  |  |  |  |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSPITAL</b>                |  |  |  |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>1/15/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>        |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balt., Md.</b>  |  |                                 |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>MacNabb Funeral Home</b>   |  |  |  |  | ADDRESS<br><b>Catonsville, Md.</b>                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Kathy McCreedy</b>      |                                 |  |

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8100530   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>DORA - LITVIN   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 28 81  |  | 2b. HOUR<br>1:45 A M  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASION   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 02 92  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN. HOSP. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a. STREET ADDRESS   |  |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH KAUFMAN   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GOLDA UNKNOWN  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-54-5492   |  | 17. INFORMANT<br>MRS. SALLY BORREL<br>3317 TERRAPIN RD. BALTO., MD 21208  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREBRAL - VASCULAR ACCIDENT<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ARTERIOSCLEROTIC HEART DISEASE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>-  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>-   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>-  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>- - - - -  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-7-1981, to 1-28-1981, that (I) (we) lost saw the deceased alive on 1-28-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>SOL LEVINSON   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/28/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. S. D. PATZL   |  |  |  | 22e. ADDRESS<br>BAL. County Gen. Hosp   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/30/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WORKMEN CIRCLE  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

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1801 4 117

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 3 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

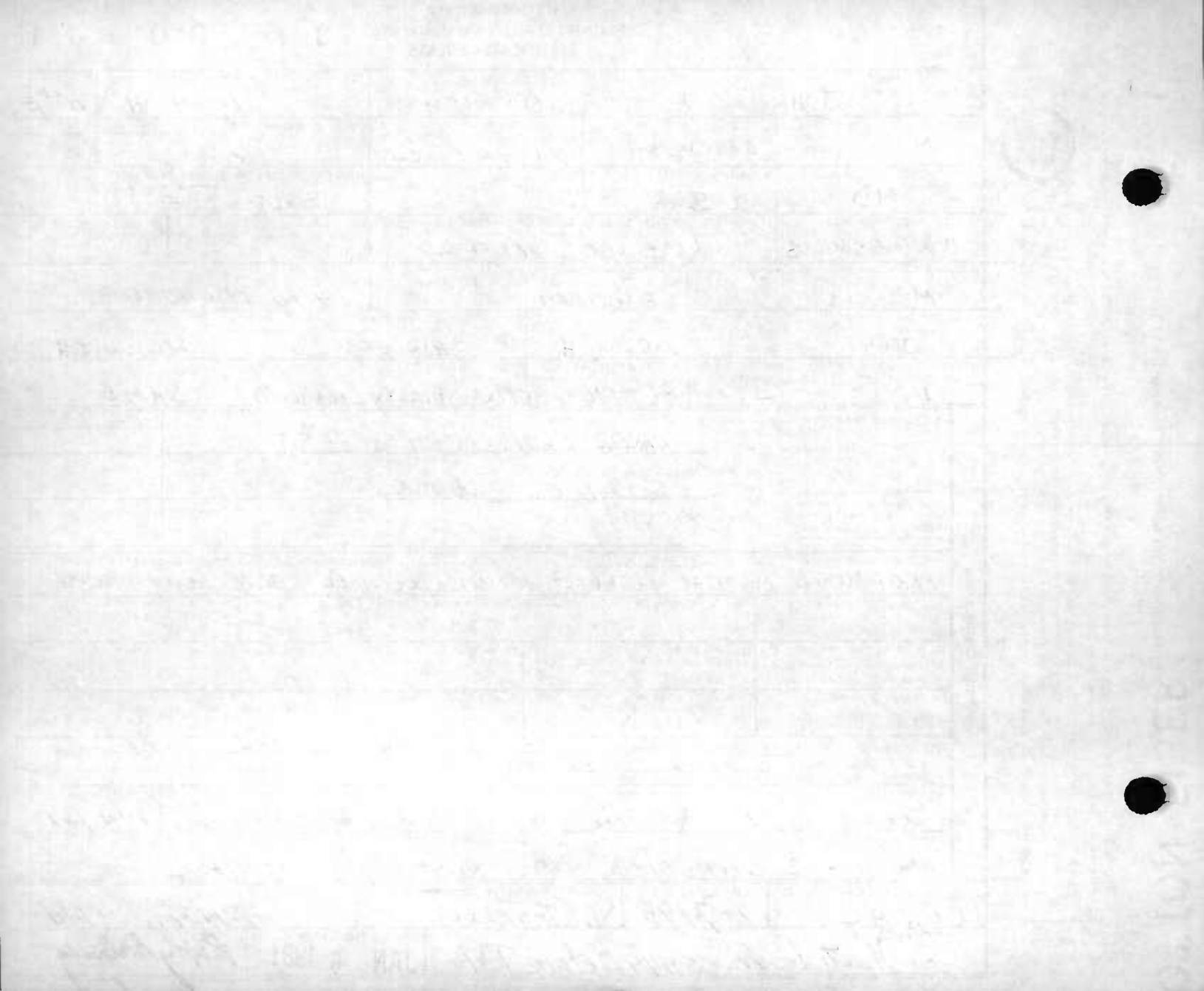
|   |  |  |   |   |  |  |   |   |  |
|---|--|--|---|---|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN H. LOCKWICH</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 4 81</b>                     |   |  | 2b HOUR<br><b>11:05 PM</b>   |   |   |  |
| 3 SEX<br><b>M</b>   |  | 4 RACE<br><b>CAUCASIAN</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 27 74</b>   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>6 YRS</b>                    |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>OWINGSMILLS</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ROSEWOOD CENTER</b> |   |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD</b>   |  | 13b COUNTY<br><b>BALTIMORE</b>   |   | 13c CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e STREET ADDRESS<br><b>4114 IDAHO AVE.</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN LOCKWICH</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SHIRLEY LOCKWICH</b> |   |  |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-90-6100</b>   |   | 17 INFORMANT<br><b>Mrs. Shirley Lockwich</b>  |  |  | ADDRESS<br><b>SAME</b>  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br><b>7803</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>SEIZURE DISORDER</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)<br><b>PROFOUND MENTAL RETARDATION; MICROCEPHALY; CONG. HEART DISEASE</b>  |  |  |   |   |  |  |   |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>12-13, 1974</b> , to <b>1-4, 1981</b> , that (I) (we) last saw the deceased alive on <b>1-4, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                     |  |  |   |   |  |  |   |   |  |
| 22b SIGNATURE<br><b>Adelina S. Gutierrez, M.D.</b>  |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br><b>1/4/81</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ADELINA S. GUTIERREZ, M.D.</b>   |  |  |   | 22e ADDRESS<br><b>ROSEWOOD CENTER</b>   |  |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>1-7-1981</b>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>  |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b> |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>J. Walter London</b>  |  |  |   | ADDRESS<br><b>5444 BELAIR RD.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 6 1981</b>  |   | 25b REGISTRAR'S SIGNATURE<br><b>Richard M. Brady</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

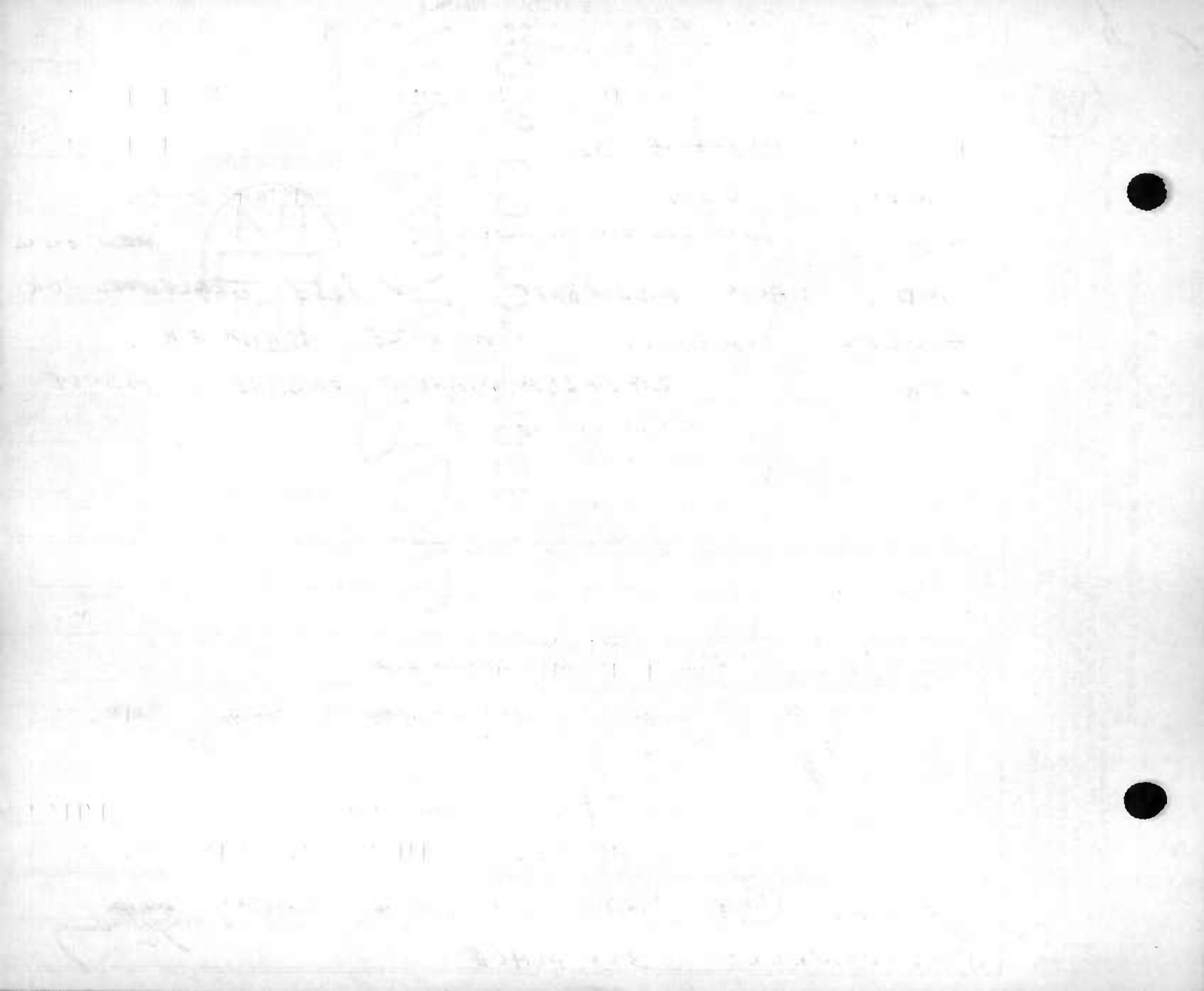


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| #5, per call w/F.H. 4/16/81 kam   |  |                   |  |   |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |   |  |  |  |  |  | REG. NO. 00532 |  |
|---|--|-------------------|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Robert Russell Lombardi  |  |                   |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED 1 10 19 81                                       |  |  |  |   |  |  |  |  |  | 2b. HOUR M     |  |
| 3. SEX Male   |  | 4. RACE White     |  | 5. DATE OF BIRTH 12/12/48   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD 1 10 19 81  |  | 2d. HOUR M 4:15  |  | 2e. HOUR M                                    |  |  |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.   |  |                   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.                       |  |   |  |  |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH Essex   |  |                   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) wooded area off New Section Rd. |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                      |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY WEST, ELEC. |  |  |  |  |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| 13a. STATE MD   |  | 13b. COUNTY BALTO |  | 13c. CITY OR TOWN MIDDLE RIVER  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 12531 GRACEWOOD DR   |  |  |  |  |  |   |  |  |  |  |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST EUGENE LOMBARDI   |  |                   |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTLE KRAMER                           |  |  |  |   |  |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNK  |  |                   |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO. 214546830   |  | 17. INFORMANT MARGIE LOMBARDI  |  |  |  | ADDRESS ABOVE  |  |   |  |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                   |  |   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |                |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of head   |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| 9651  |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF  |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| 19a. DATE OF OPERATION  |  |                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? AM 1 10 19 81  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot   |  |  |  |  |  |   |  |  |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE off New Section Rd., Essex, Balto., MD.   |  |  |  |  |  |   |  |  |  |  |  |                |  |
| 22a. I certify that I am in charge of the remains described above, held in Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                   |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| ACTUAL SIGNATURE Thomas D. Smith  |  |                   |  | TITLE (SPECIFY) M.D. Deputy Chief   |  |  |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED 1/11/81  |  |   |  |  |  |  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.   |  |                   |  | ADDRESS 111 Penn St. Balto., MD.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  |                   |  | 23b. DATE 1/14/81   |  | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD                                   |  |  |  |   |  |  |  |  |  |                |  |
| 24. FUNERAL DIRECTOR NAME J.G. CONNELLY   |  |                   |  | ADDRESS 300 MACE  |  |  |  | 25a. DATE REC'D. BY REGISTAR   |  |  |  | 25b. REGISTRAR SIGNATURE   |  |   |  |  |  |  |  |                |  |





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 3 3

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |   |  |  |  |                                   |  |
|---|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alice M. Lopez</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>January</b> DAY <b>2</b> YEAR <b>1981</b> |  | 2b. HOUR<br><b>12:25A</b>  |  |                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>May 27, 1900</b> YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10503 Gateridge Road</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Cockeysville</b>   |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>10503 Gateridge Road</b>   |                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Powers</b> LAST  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>Dunn</b> LAST  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 05 3589</b>   |   | 17. INFORMANT<br><b>Joseph Lopez</b>   |  | ADDRESS<br><b>Same</b>   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Disease</b><br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b>  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension</b>   |  |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 15, 1980</b> to <b>Jan 2, 1981</b> , that (I) (we) last saw the deceased alive on <b>Sept 15, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |   |  |  |  |                                   |  |
| 22b. SIGNATURE<br><b>Sheldon Goldgeier</b>  |  |  |   | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Sheldon Goldgeier</b>   |  |  |   | 22e. ADDRESS<br><b>711 W. 40th Street Baltimore, Md.</b>   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5 Jan. 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey, Howard Co. Maryland</b>   |                                   |  |
| 24. FUNERAL DIRECTOR<br><b>Burgee Funeral Home</b>  |  |  |   | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 5 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8100534   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LeRoy H. LOWENTHAL, SR.   |  |  |  | 2b. HOUR 2 A.M.  |  |   |  |
| 3 SEX MALE  |  | 4 RACE WHITE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>JUNE 28, 1900  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.  |  |
| 10 CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7 SLADE AVE., APT. 514 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>VICE PRES./DIRECTOR SAVINGS & LOAN  |  | 12b. KIND OF DEATH EVENT OR INDUSTRY  |  |
| 13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTO.   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MOSES LOWENTHAL  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MINNIE ROSE  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO. 219-32-1201   |  | 17. INFORMANT MRS. FLORA LOWENTHAL, APT. 514<br>7 SLADE AVE. BALTO., MD 21208  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic degenerative brain disease</u><br>3319<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June, 1976</u> , 19 <u>81</u> , to <u>January 22, 1981</u> , that (I) (we) lost <u>saw the deceased alive on January 22, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>John J. Mann</u> DEGREE _____   |  |  |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 1/23/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. MANN, M.D.  |  |  |  | 22e. ADDRESS 611 PARK AVE. BALTO., MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 1/25/81  |  | 23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100535

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |  |
|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>RICHARD</b> MIDDLE <b>SAMUEL</b> LAST <b>LUCAS</b><br><b>RICHARD LUCAS</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN 25 1981</b>                                       |   | 2b. HOUR<br><b>845 P M</b>                        |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 13 05</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>75</b>               |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CO. MD</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VALLEY NRSNG + CONVALESCENT HOME</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STEELWORKER</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b> |  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>BALTO</b>  | 13c. CITY OR TOWN<br><b>Essex</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>21221 613 S. MARLYN AVE</b>           |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Harry</b> MIDDLE <b>Thomas</b> LAST <b>Lucas</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Olive</b> MIDDLE <b>Marie</b> LAST <b>Miller</b>   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>070-10-7578</b>  |   | 17. INFORMANT<br>NAME <b>Anna F. Feit</b> ADDRESS <b>Same</b>   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **ADULT ONSET DIABETES MELLITUS****2500**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**CHRONIC MYELOGENOUS LEUKEMIA**

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 20</b> , 19 <b>81</b> , to <b>JAN 25</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>JAN 21</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Stephen K. Dym</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |  | 22c. DATE SIGNED<br><b>1/26/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN K. DYM</b>   |  | 22e. ADDRESS<br><b>8501 LA SALLE RD POWSON MD 2104</b>                 |  |   |  |   |  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                          | 23b. DATE<br><b>1-28-81</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Mem. Gardens</b>                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>BRZDZINSKI</b> ADDRESS <b>PA 1407 Old Eastern Ave.</b> |                             | 25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1981</b> 25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

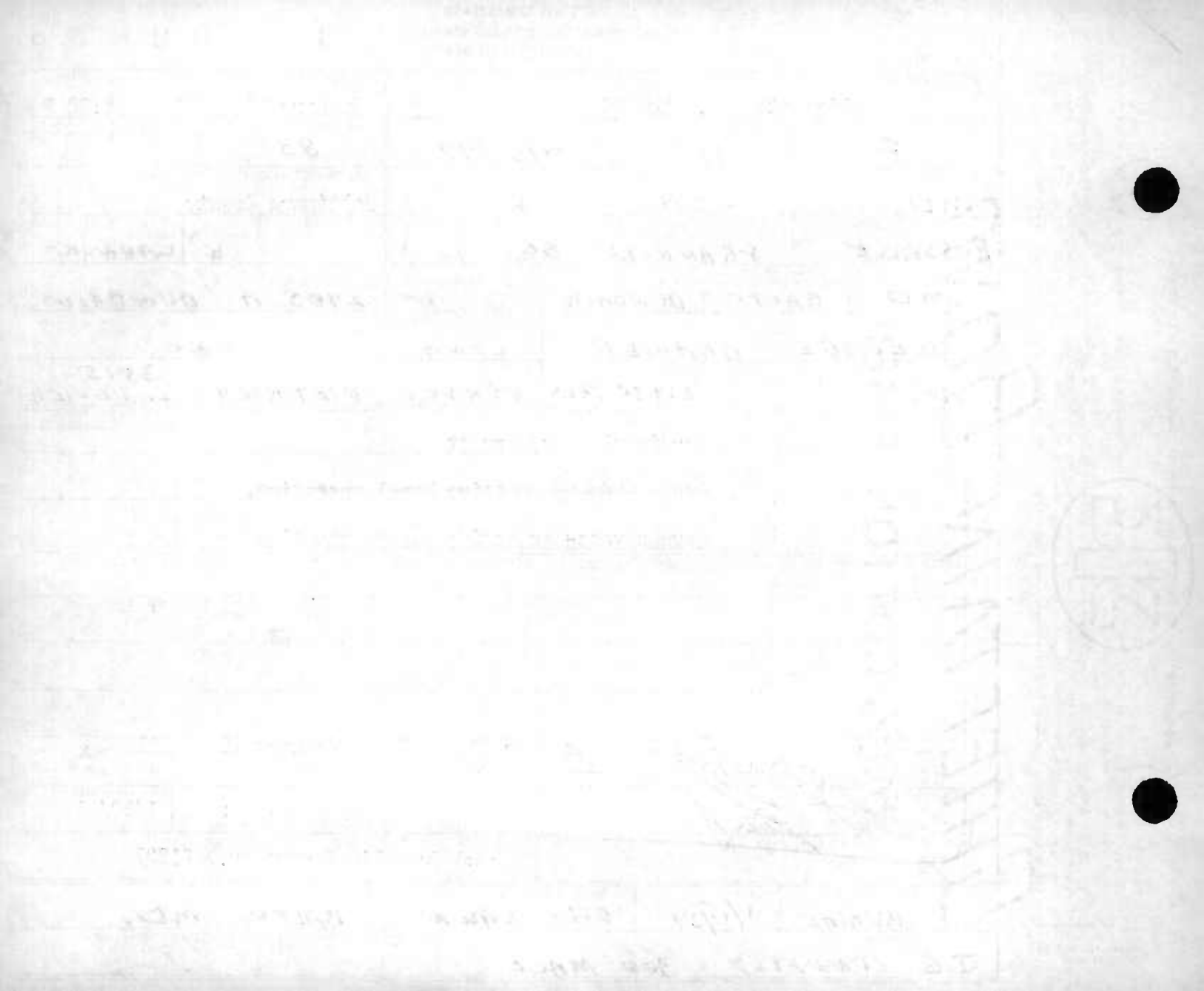
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |   |  |  | 8100536  |  |
|--|--|--|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |   |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth R. LUEDECKE   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 12, 1981          |   |  | 2b. HOUR<br>4:38 P.M.  |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7/5/97  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS                        |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD      |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>LAUNDRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |  | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>DUNDALK   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>2908 A. DUNBRIN   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE KRAMER  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LENA UNK   |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214303264   |  | 17. INFORMANT<br>ADDRESS<br>VERNON DIETRICH 3515 LONGVIEW   |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute abdomen, massive bowel resection.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cerebrovascular accident, hypertension |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from December 20, 1980, to January 12, 1981, that (we) last saw the deceased alive on January 12, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.               |  |  |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Pedro Pina   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |   | 22c. DATE SIGNED<br>1/12/81                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  |   |  | 23b. DATE<br>1/15/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.E. CONNELLY  |  |  |  |   |  | ADDRESS<br>300 MACE  |   | 25a. DATE BY REGISTRAR<br>JAN 18 1981          |  | 25b. REGISTRAR'S SIGNATURE                             |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 81 00537   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Elwood Vernon Lyon, Sr.</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 17, 1981</b>   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>December 17, 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>81</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>206 Warren Road</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Master Plumber</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>  |  |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br><b>206 Warren Road</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Deems Lyon</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Manie ----- Wilhelm</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-7834A</b>   |  | 17. INFORMANT ADDRESS<br><b>Elwood V. Lyon, Jr. 207 Glenmore Avenue</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>G. I. Bleeding</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gastric malignancy</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b><br><b>2 months</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic obstructive pulmonary disease</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1973</b> , to <b>Jan. 17, 1981</b> , that (I) (X) last saw the deceased alive on <b>Sept. 29, 1980</b> , and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Donald O. Wood</b>   |  |  |  | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  | 22d. DATE SIGNED<br><b>1/19/81</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Donald O. Wood</b>  |  |  |  | 22f. ADDRESS<br><b>York &amp; Greenmeadow Dr. Timonium, Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/20/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto. Co., Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>J. E. Lowell Lemmon</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kennedy</b>   |  |
| 25c. ADDRESS<br><b>U. E. Lowell Lemmon, 10 W. Padonia Road, Tim.</b>  |  |  |  |   |  |   |  |

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI (100-33-193) FROM : SAC, COCKEYVILLE (100-111)

SUBJECT: MURDER OF MARTIN LUTHER KING, JR.; CIVIL RIGHTS; RACIAL MATTERS

RE: COCKEYVILLE, MARYLAND, APRIL 4, 1968

TO : DIRECTOR, FBI (100-33-193) FROM : SAC, COCKEYVILLE (100-111)

SUBJECT: MURDER OF MARTIN LUTHER KING, JR.; CIVIL RIGHTS; RACIAL MATTERS

RE: COCKEYVILLE, MARYLAND, APRIL 4, 1968

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RE: COCKEYVILLE, MARYLAND, APRIL 4, 1968

TO : DIRECTOR, FBI (100-33-193) FROM : SAC, COCKEYVILLE (100-111)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00538

|   |         |   |                   |  |  |
|---|---------|---|-------------------|--|--|
| 1. FOR STATE REGISTRAR  |         | 2a. DATE KNOWN OF DEATH                                     |                   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 2c. DATE PRONOUNCED DEAD                                    |                   | 2d. HOUR   |  |
| LORRAINE D. MACK.   |         | 1/11 1981   |                   | M  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | IF UNDER 1 YR.   | IF UNDER 24 HRS.   |
| F   | W       | 5/28/98   | 82 YRS.           | MONTHS   | DAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                                |                   | 8. MARRIED   |  |
| PA.   |         | USA   |                   | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| ESSEX   |         | 725 MIDDLESEX RD  |                   | BALTO. COUNTY MD.  |  |
| 13a. STATE  |         | 13b. CITY OR TOWN   |                   | 13c. INSIDE CITY LIMITS?   |  |
| MD.   |         | BALTO   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                    |                   | 16. SOCIAL SECURITY NO.  |  |
| WILLIAM   |         | MARY SHAULER BACH   |                   | 21210 7396   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 17. INFORMANT   |                   | ADDRESS  |  |
| NO  |         | RUSSELL MACK  |                   | ABOVE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |   |                   |  |  |
| PART I DEATH WAS CAUSED BY:   |         |   |                   |  |  |
| IMMEDIATE CAUSE (a) Congestive Cardiac Failure  |         |   |                   |  |  |
| 4269 } DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |  |  |
| (b) Complete Heart Block  |         |   |                   |  |  |
| } DUE TO, OR AS A CONSEQUENCE OF  |         |   |                   |  |  |
| (c) on gate maker   |         |   |                   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |   |                   |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |  | 20. AUTOPSY?   |
|   |         |   |                   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY   |                   | 21c. HOW INJURY OCCURRED   |  |
|   |         | HOUR A.M. MONTH DAY YEAR                                    |                   | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   | 21f. LOCATION  |  |
|   |         |   |                   | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |                   |  |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |                   | DATE SIGNED  |  |
| K.S. AHLUWALIA  |         | Deputy  |                   | 1/12/81  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS   |                   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |
| K.S. AHLUWALIA  |         | 2112, Dundee Ave Balto 21222                                |                   | BURIAL   |  |
| 23b. DATE   |         | 23c. NAME OF CEMETERY OR CREMATORY                          |                   | 23d. LOCATION  |  |
| 1/14/81   |         | BALTO. NATL   |                   | BALTO. MD.   |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR                               |                   | 25b. REGISTRAR'S SIGNATURE   |  |
| J.G. CONNELLY   |         | JAN 19 1981   |                   | R. G. Connelly   |  |

THE UNIVERSITY OF CHICAGO PRESS

LEARNING TO READ

by J. H. B. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 3 9

REG. NO.

|  |  |  |  |   |   |  |   |  |   |  |
|--|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM <i>Gilbert</i> MACKBEE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 7 '81</b>                  |   |   | 2b. HOUR<br><b>6:30A M</b>   |   |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 16 1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF ANY IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auditor</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balting city</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD.</b>   |  |  |  |   | 13b. COUNTY<br><b>Anne Arundel</b>                                      |  | 13c. CITY OR TOWN<br><b>Pasadena</b>                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Martin MackBee</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose C. Drussel</b> |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>U.W. 2</b>   |  | 17. INFORMANT<br><b>Henrietta C. Macbbee same as 13</b>   |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Probable CAD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Hour</b><br><b>20 Yr. History</b>                                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Metastatic Duodenal Cancer</b>  |  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-31</b> , 19 <b>80</b> , to <b>1-7</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1-7</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>John D. Gaare</b>   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/7/80 81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. John D. Gaare</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>6701 N. Charles St. 21204</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>  |  |  | 23b. DATE<br><b>1/10/1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>       |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Glen Burnie, Anne Arundel Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mc Cully F.H. Mountain &amp; Tick Neck Rds. 21122</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |

MEDICAL CERTIFICATION

9  
9

1





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 4 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |  |   |  |
|---|--|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Julia Marie MacKessy</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 23, 1981</b> |   | 2b. HOUR a.m.<br><b>8:00</b>  |  |  |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 5 96</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Nursing Home</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD.</b>  |  |   | 13b. CITY OR TOWN<br><b>Balto.</b>                          |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13d. STREET ADDRESS<br><b>4309 Wilkens Ave. (21229)</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Barranger</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-48-6966</b>              |   | 17. INFORMANT ADDRESS<br><b>St. Joseph's N.H., 1222 Tugwell Dr. (21228)</b>                     |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Arrest, Arteriosclerotic</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Circulatory Collapse</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Serious Cerebral Ischemia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 20</b> 19 <b>77</b> , to <b>23 Jan</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>22 Jan</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Joseph E. Muse Jr. MD</b>  |  |   |   | 22c. DATE SIGNED<br><b>1/23/81</b>  |   | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph E. Muse, Jr. MD.</b>   |  |   |   | 22f. ADDRESS<br><b>Wilkens and Pine Heights Avenue</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/26/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Natl. Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>History McBrady</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

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3. *Conclusions*

Abstract

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1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 26

2000-11-11

on

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 4 1

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  | FIRST MIDDLE LAST<br>Clifford J. Madden   |  | MONTH DAY YEAR<br>January 8, 1981   |  | 12:15A   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 22, 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Josephs Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Letter Carrier  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael Madden  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Kimball  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>705-05-5386  |  |
| 16c. INFORMANT<br>Mrs M. May Madden   |  | 16d. ADDRESS<br>Same  |  | 17. INFORMANT<br>Mrs M. May Madden  |  | 17. ADDRESS<br>Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1579 Pancreatic Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (b) With Generalized Abdominal Metastasis<br>DUE TO, OR AS A CONSEQUENCE OF (c) abdominal metastases   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/6/80 to 1/8/81, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/8/81, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  | 22b. SIGNATURE<br>Adel S. El-Hennawy, M.D.  |  | 22c. DATE SIGNED<br>1-8-81  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Adel El-Hennawy, M.D.  |  | 22e. ADDRESS<br>7620 York Road, Towson, Md. 21204   |  | 22f. MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/10/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>Patricia Kennedy  |  |  |  |

BP



TO: Mr. J. Edgar Hoover

FROM: Mr. W. J. [illegible]  
[illegible]  
[illegible]

12-3-11

1961 - 1962

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 4 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>EMMA B. MADLEM   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 - 9 - 81             |   |  | 2b. HOUR<br>10 58 M   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 20 00  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80<br>IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST JOSEPH HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |   |  |   |  |   |  |
| 13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Baltimore                                   |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas Borry   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Leisey |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |  | 17. INFORMANT<br>Miss Naomi Madlem (daughter) Same as #13   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC DYSPHYTHMIA</u><br>429.2 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) <u>ASCVD</u><br>gave rise to immediate }<br>cause (a), stating the } DUE TO, OR AS A CONSEQUENCE OF<br>underlying cause lost. } (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINS<br>YRS |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>9/12/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ST. JOSEPH'S HOSPITAL  |  |   |  | 22e. ADDRESS<br>ST. JOSEPH'S HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/12/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Emanuel Lutheran Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brickerville PA.                |  |
| 24. FUNERAL DIRECTOR<br>NAME E. Barnes<br>Fleming Funeral Service - Benson, Md. 21018   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1981  |  |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

15-7-51

4-1-51

15-7-51

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 00543

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ERNEST L. MAFFEI, JR.</b><br><b>ERNEST L. MAFFEI</b> |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>29</b> YEAR <b>81</b><br><b>1/29/81</b>   |  | 2b. HOUR<br><b>4:30 PM</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>24</b> YEAR <b>24</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>America USA</b>   |  | 6. AGE (YEARS LAST BIRTHDAY)<br><b>56</b> YRS.<br>IF UNDER 1 YEAR: MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9619 Dundawan Road</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>   |  | 13a. STREET ADDRESS<br><b>9619 Dundawan Rd</b><br><b>9619 Dundawan Road, 21236</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 14. FATHER<br>(FIRST MIDDLE LAST)<br><b>ERNEST</b>  |  | 15. MOTHER'S MARRIAGE NAME<br>(FIRST MIDDLE LAST)<br><b>DAISY ROSSI</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b><br>(IF YES, GIVE WAR OR DATES) <b>WW II</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-16-4803</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Alice E. Maffei, wife, same address</b>   |  |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intraabdominal bleeding.</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cancer of Rectum with liver metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>and retroperitoneal metastases</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |

MEDICAL CERTIFICATION

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><b>12/4/1980</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of rectum with liver metastases</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)<br><b>NA</b> |  |   |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/26/80</b> to <b>12/16/80</b> , that (I) (we) last saw the deceased alive on <b>11/23/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>M.S. Didolkar M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/30/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.S. DIDOLKAR</b>   |  |   |  | 22e. ADDRESS<br><b>UNIV. OF MARYLAND Hosp.</b><br><b>22 SO. Green St Baltimore Md 21201</b> |  |   |  |

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>1/31/81</b>                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>   |  | 9705 Belair Road<br><b>Balto., Md. 21236</b> |  | 25. DATE RECEIVED BY REGISTRAR<br><b>1/30/81</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |   |  |  |
|---|--|--|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |  |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Mary Jane Malone  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>1 16 81 2:20P <sub>M</sub>  |   |  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 13. 1931  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BMC 6701 N. Charles St. 21204 |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Civil Service    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Harford Co.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Harford  |  |  |   |   | 13c. CITY OR TOWN<br>Bel Air   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>69 Ellendale Street |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Schulze  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Hazel Strine   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No None  |  |  |   |   | 16b. SOCIAL SECURITY NO.<br>215-28-4635  |   | 17. INFORMANT ADDRESS<br>Edward L. Malone (husband) Same as # 13                             |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)    |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16, 19 81, to 1/16, 19 81, that (I) (we) last saw the deceased alive on 1/16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br>Teh-ching Wang  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>1/16/81   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Teh-Ching Wang   |  |  |   |   | 22e. ADDRESS<br>6701 N. Charles St. 21204  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>1/19/1981  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cemetery   |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>E. Barnes  |  |  |   |   | 24b. ADDRESS<br>Fleming Funeral Service - Benson, Md. 21018  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 19 1981                      |   |  |  |



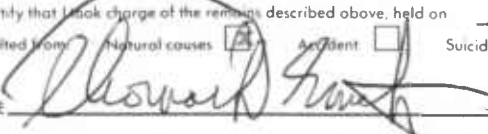
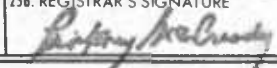
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |  |  |   |  |  |  |  | REG. NO. 00545 |  |
|--|----------------------|--|--|--|---|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Patricia R. Manning</b>  |                      |  |  |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>10</b> YEAR <b>1981</b>        |  | 2b. HOUR <b>M</b>  |  |                |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH MONTH <b>7</b> DAY <b>9</b> YEAR <b>33</b>  | 6. AGE (IN YEARS) LAST BIRTHDAY <b>47</b> YRS. | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>10</b> YEAR <b>1981</b>   |  | 2d. HOUR <b>1:14</b> <b>M</b>  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pittsburg Pa.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County,</b> MD.  |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                      |  |  |  |   |  |  |  |  |                |  |
| 13a. STATE <b>Md.</b>  |                      | 13b. CITY OR TOWN <b>Balto.</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13d. STREET ADDRESS <b>12351 Bondcrest Drive</b>   |  |  |  |                |  |
| 14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b></b> LAST <b>Jones</b>  |                      |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Catherine</b> MIDDLE <b></b> LAST <b>Wadock</b>  |   |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>164-28-1552</b>  |  | 17. INFORMANT ADDRESS <b>Mr. Edward F. Manning Reisterstown, Md.</b>   |   |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>4280</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>(c) <b></b>  |                      |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |                      |  |  |  |   |  |  |  |  |                |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |                |  |
| 21g. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |  |  |   |  |  |  |  |                |  |
| ACTUAL SIGNATURE    |                      | M.D. <b>Thomas D. Smith, M.D.</b>  |  | TITLE (SPECIFY) <b>Deputy Chief</b>  |   | MEDICAL EXAMINER   |  | DATE SIGNED <b>1/11/81</b>   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |                      | ADDRESS <b>111 Penn St. Balto., MD.</b>  |  |  |   |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>1-15-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Union Dale Cemetery</b>  |   | 23d. LOCATION CITY OR TOWN <b>Pittsburg Pa.</b> COUNTY STATE   |  |  |  |                |  |
| 24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home</b> ADDRESS <b>Reisterstown, Md. 21136</b>   |                      |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |                  |   |  |
|--|--|--|--|---|--|---|------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO. 8100546                                   |   |  |   |                  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ETHEL AUGUST MARCH  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN 17 1981 |   |  | 2b. HOUR<br>M   |                  |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/18/07   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.  |                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. COUNTY MD.                                       |                  |   |  |
| 10. CITY OR TOWN OF DEATH<br>ESSEX   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>510 RIVERSIDE DR. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWE                        |                  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>ESSEX  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  | 13e. STREET ADDRESS<br>510 RIVERSIDE DR   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES WHITE  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JULIA BLOODS WORTH   |  |   |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>UNK   |  | 17. INFORMANT<br>JOHN MARCH   |  |   | ADDRESS<br>ABOVE |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) AASCUD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 HR<br>15 yrs |  |  |  |   |  |   |                  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |                  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-20 1980 to 1/17 1981, that (I) (we) last saw the deceased alive on 12/29 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |   |  |   |                  |   |  |
| 22b. SIGNATURE<br>John V. Conway, MD   |  |  |  |   |  | DEGREE<br>MD  |                  | 22c. DATE/SIGNED<br>1/19/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John V. Conway MD   |  |  |  | 22e. ADDRESS<br>3401 Dundalk Ave, Balt, Md. 21222   |  |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/21/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY  |  |  |  | ADDRESS<br>300 MACE   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1981  |                  | 25b. REGISTRAR'S SIGNATURE<br>Hickey/McBready   |  |



CONFIDENTIAL

CONFIDENTIAL





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  | 30 P.M.                                      |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | FANNYE MARGOLIN   |  | JAN. 11, 1981   |  | 10   |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7 YRS.                                       |  |
| FEMALE   |  | WHITE  |  | AUG. 20, 1901   |  | 79  |  |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7c. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  | MD.  |  |
| RUSSIA   |  | USA  |  |   |  | BALTIMORE COUNTY  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| BALTIMORE  |  | 4207 MILFORD MILL RD.  |  | HOUSEWIFE   |  | AT HOME   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |
| MARYLAND   |  | BALTO.   |  | BALTIMORE   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 4207 MILFORD MILL RD. #21208                 |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT                                 |  |
| LOUIS  |  | SOPHIE   |  | NO  |  | 212-32-8200   |  | MRS. GERMAINE ROSENTHAL                      |  |
|  |  |  |  |   |  |   |  | 4207 MILFORD MILL RD. #21208                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Cerebro vascular accident</u>   |  |  |  |   |  |   |  |  |  |
| 4360 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |  |  |
| (b) <u>HYPERTENSION</u>  |  |  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  |
| (c)  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
|  |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
|  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> 19 to <u>1980</u> 19, that (I) (we) last saw the deceased alive on <u>12/15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Leonard A. Golombek</u>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><u>1/12/81</u>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEONARD GOLOMBEK, M.D.  |  |  |  | 22e. ADDRESS<br>5400 OLD COURT RD. RANDALLSTOWN, MD 21133   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>JAN. 12, 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>EAST VIEW   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CUMBERLAND MARYLAND   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & SONS, INC.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCreedy</u>                |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director, page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |                           | 8100548 |  |
|--|--|--|--|---|--|---|--|---|---------------------------|---------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |   |                           |         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Patricia M Marjenhoff</i>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>January 3, 1981</i>                                      |  |   | 2b. HOUR<br><i>1:20AM</i> |         |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>July 23, 1934</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>46</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |                           |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>England</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>England</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                             |  |   |                           |         |  |
| 10. CITY OR TOWN OF DEATH<br><i>Perry Hall</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>5 Whitlaw Place</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Office Manager</i>          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                           |         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13b. STREET ADDRESS<br><i>5 Whitelaw Place</i>  |                           |         |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Perry Hall</i>  |  |   |  |   |                           |         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Lyall A Joyce</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Vera G White</i>   |  |   |  |   |                           |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>435-50-1748</i>   |  | 17. INFORMANT ADDRESS<br><i>Mr Lyall A Joyce Same</i>   |  |   |  |   |                           |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio-respiratory failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized metastases</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of the Ovary</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 weeks</i><br><i>2 years</i><br><i>2 years</i> |  |  |  |   |  |   |  |   |                           |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |                           |         |  |
| 19a. DATE OF OPERATION<br><i>12/20/80</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>1830</i>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |                           |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (EXPLAIN NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |                           |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>6701 North Charles St Baltimore, Md</i>   |  |   |  |   |                           |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/20/80</i> to <i>1/3/81</i> , that (I) (we) last saw the deceased alive on <i>12/20/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.   |  |  |  |   |  |   |  |   |                           |         |  |
| 22b. SIGNATURE<br><i>George J Richards Jr</i><br>22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | DEGREE<br><i>MD</i><br>22c. ADDRESS<br><i>6701 North Charles St Baltimore, Md</i>   |  | 22d. DATE SIGNED<br><i>1/5/81</i>   |  | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                           |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>  |  | 23b. DATE<br><i>1/6/81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>                        |  |   |                           |         |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Leonard J Ruck Inc. Baltimore, Maryland</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 7 1981</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Rufus McBrady</i>  |  |   |                           |         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 81 00549<br>REG. NO.  |  |  |                             |   |
|---|--|---|--|---|--|--|-----------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Laura Lee MARTIN   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 19, 1981   |  |  |                             | 2b. HOUR<br>8:40 P.M.   |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 8, 1925   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   |                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |                             |   |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Metalurgist  |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Mill   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Middle River  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |  |                             |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT<br>Harland H. Martin, husband   |  | ADDRESS<br>Same  |                             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br><u>1749</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of breast, metastatic</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                             |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                             |   |
| 22a. I certify that (this hospital) attended the deceased from <u>January 16</u> , 19 <u>81</u> , to <u>January 19</u> , 19 <u>81</u> , that (we) lost saw the deceased alive on <u>January 19</u> , 19 <u>81</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |                             |   |
| 22b. SIGNATURE<br><u>Carol Pressey</u><br>22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Carol Pressey, M.D.  |  |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  | 22c. DATE SIGNED<br>1/19/81 |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>1-21-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |                             |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bruzdinski Funeral Home PA  |  |   |  | ADDRESS<br>1407 Old Eastern Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1981   |                             | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |   |  |   | 81 00550   |  |  |  |
|---|--|---|--|---|---|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |  |   |  |   |  |  |  |  |
| 1. DECEASED NAME<br>(Type in full)<br>FIRST MIDDLE LAST<br>RONZO (nmn) MATHES   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 14, 1981  |  |   |  |   |  | 2b. HOUR<br>7:15 PM                        |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 15, 1909 |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.              |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                      |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(If not in such facility, give street address)<br>SAINT JOSEPHS HOSPITAL |  |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter(ret)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |  |  |
| 13a. STATE<br>MARYLAND  |  |   |  |   | 13b. COUNTY<br>A.A.   |  | 13c. CITY OR TOWN<br>PASADENA   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>202 Magonlia Avenue |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>David Augustus Mathes   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Emeline Adams   |  |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT (Son)<br>ADDRESS 407 Doris Ave.<br>Mr. Kenneth Mathes Brooklyn Park |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Congestive Cardio myopathy</i><br>4254<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Severe Chronic Obstructive Pulmonary disease</i> |  |   |  |   |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  |   |  |   |   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JANUARY 10 19 81</u> to <u>JANUARY 14 19 81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JANUARY 14 19 81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |   |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>A.H. Ghiladi</i>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  |   | 22c. DATE SIGNED<br>1-15-81  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.H. GHILADI   |  |   |  |   | 22e. ADDRESS<br>7600 OSLER Dr. Towson 21204   |  |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  |   | 23b. DATE<br>17 JAN. 81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge MEM. Park                       |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. Easter   |  |   |  |   | ADDRESS<br>Glen Burnie Md. 21061  |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 16 1981                                       |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Barry McCreedy</i>  |  |  |  |

BP



WILKINSON COUNTY

TOWNSHIP

Conservator of the Peace  
of the County of

James Thomas, Esq.

ALL RIGHTS RESERVED  
MAY 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100551

REG. NO.

|  |  |  |  |   |  |   |   |  |   |  |
|--|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Pauline R. MAYNOR</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 14, 1981</b>         |   |  | 2b. HOUR<br><b>2:40 P.M.</b>  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 20, 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD.                   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Essex</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>604 Virginia Avenue 21221</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Davis</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Talbert</b>  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220 24 2908</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Allen H. Maynor, husband</b>  |   |   |  | <b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>Cardiopulmonary arrest</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Gastrointestinal bleeding; anemia; cholelithiasis; depression</b>   |  |  |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 16, 1980</b> , to <b>January 14, 1981</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 14, 1981</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do) view the body after death. |  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><i>Naeem Gauhar M.D.</i>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/14/81</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Naeem Gauhar M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1-18-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Mem. Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Beckley, West Virginia</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bruzdzinski Funeral Home</b>  |  |  |  |   | ADDRESS<br><b>PA 1407 Old Eastern Ave</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McCready</i>    |  |

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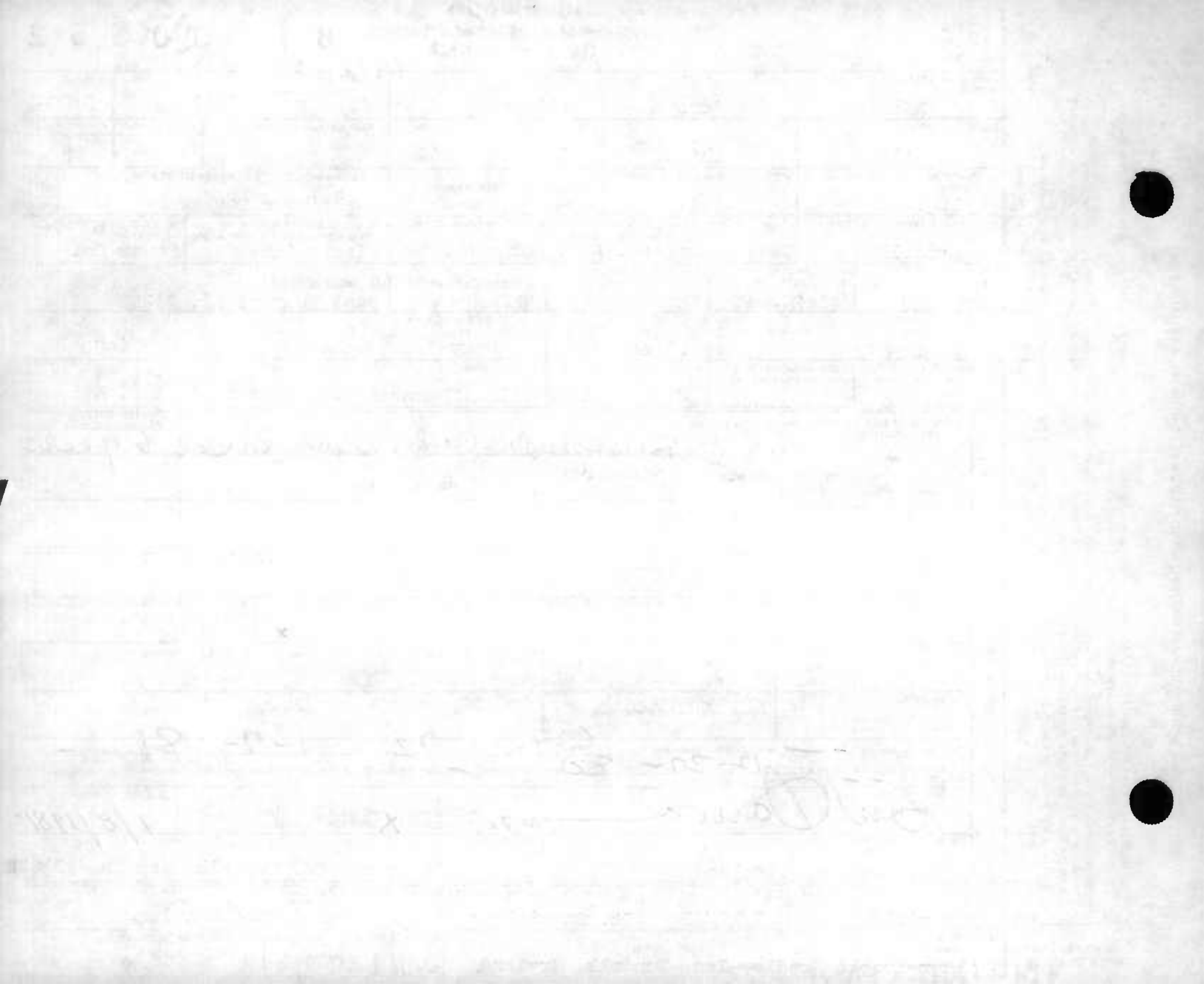
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |                                    |  |   |  |                        |  |  |
|--|--|--|---|--|------------------------------------|--|---|--|------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7. REG. NO.  |   | 8 1 0 0 5 5 2  |                                    |  |   |  |                        |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |  |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  | 2b. HOUR               |  |  |
| Michael Joseph McAleer   |  |  |   |  |                                    | January 7, 1981  |   |  | 9:00 PM                |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR MONTHS DAYS                                 |                        | 7. IF UNDER 24 HRS. HOURS MIN.               |  |
| Male   |  | White  |   | 7 10 1892  |                                    | 88 YRS.  |   |  |                        |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |                        |  |  |
| England  |  | U.S.A.   |   |  |                                    | Baltimore County MD  |   |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                        |  |  |
| Dundalk  |  | 2900 Dunran Rd. Apt. A-1   |   |  |                                    | Blacksmith   |   | Power Co.  |                        |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. CITY OR TOWN   |  |                                    | 13d. INSIDE CITY LIMITS?   |   |  | 13e. STREET ADDRESS    |  |  |
| Maryland   |  |  | Baltimore   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |  | 2903 Dunmore Rd. 21222 |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |                                    |  |   |  |                        |  |  |
| James McAleer  |  |  | Mary Dowling  |  |                                    |  |   |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |   | 17. INFORMANT ADDRESS  |                                    |  |   |  |                        |  |  |
| No   |  | 059/01/7679  |   | Ellen Thornton 2900 Dunran Rd. Apt. A-1 Dundalk, Md 21222  |                                    |  |   |  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |                                    |  |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary atherosclerotic Cardiovascular Disease</i>   |  |  |   |  |                                    |  |   |  |                        | 6 years                                      |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                    |  |   |  |                        |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |   |  |                                    |  |   |  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |                                    |  |   |  |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |                                    |  |   |  |                        |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                        |  |  |
|  |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                        |  |  |
|  |  |  | P.M. 19   |  |                                    |  |   |  |                        |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |                        |  |  |
|  |  |  |   |  |                                    |  |   |  |                        |  |  |
| 22a. I certify that (1) <del>(this hospital)</del> attended the deceased from <i>6-9-77</i> to <i>1-7-81</i> , that (1) <del>(we)</del> lost saw the deceased alive on <i>1-7-77</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>(we)</del> <del>(did not)</del> view the body after death. |  |  |   |  |                                    |  |   |  |                        |  |  |
| 22b. SIGNATURE <i>Dr. Bernard W. Sollod</i>  |  |  |   |  |                                    | DEGREE <i>M.D.</i>   |   | 22c. DATE SIGNED <i>1/8/1981</i>                               |                        |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |                                    | 22e. ADDRESS   |   |  |                        |  |  |
| Dr. Bernard W. Sollod  |  |  |   |  |                                    | 2900 Dunran Rd, Dundalk, Maryland 21222  |   |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |                        |  |  |
| Burial   |  |  | 1/10/81   |  | St. Stanislaus                     |  | Baltimore, Maryland                     |  |                        |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |                        |  |  |
| Walter Brooks Bradley Inc. Dundalk, Maryland   |  |  |   |  |                                    | JAN 14 1981  |   | <i>Robert K. ...</i>   |                        |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |               |  |                   |  |                |  |  |
|--|--|--|--|--|---------------|--|-------------------|--|----------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MARY   |  | MIDDLE ELOISE  | LAST McLELLAN |  | 2a. DATE OF DEATH |  | MONTH DAY YEAR | 2b. HOUR   |  |
|  |  |  |  |  |               |  | 1-27-81           |  | 12             | P M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |               | 6. AGE (IN YEARS LAST BIRTHDAY)  |                   | IF UNDER 1 YEAR  |                | IF UNDER 24 HRS  |  |
| Female   |  | White  |  | April 4 1890   |               | 90   |                   | MONTHS DAYS  |                | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                   |  |                |  |  |
| Maryland   |  | U. S. A.   |  |  |               | Baltimore County   |                   | MD.  |                |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |               |  |                   |  |                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Randallstown   |  | Baltimore County General Hosp.   |  |  |               |  |                   |  |                | Homemaker  |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |               | 13d. STREET ADDRESS  |                   | 12b. KIND OF BUSINESS OR INDUSTRY                        |                |  |  |
| Virginia   |  | Arlington  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |               | 3515 North Washington Blvd.  |                   | Arlington, Virginia                                      |                |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |               |  |                   |  |                |  |  |
| James B. Yeatman   |  |  |  | Mary M. Mitchell   |               |  |                   |  |                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |               | ADDRESS  |                   |  |                |  |  |
| No   |  | 215 01 4378 D  |  | Miss Ruth C. Yeatman   |               | 21 Bellclara Circle  |                   | Sparks 21152   |                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |               |  |                   |  |                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |               |  |                   |  |                |  |  |
| IMMEDIATE CAUSE (a) Chronic renal failure  |  |  |  |  |               |  |                   |  |                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |               |  |                   |  |                |  |  |
| (b)  |  |  |  |  |               |  |                   |  |                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |               |  |                   |  |                |  |  |
| (c)  |  |  |  |  |               |  |                   |  |                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |               |  |                   |  |                |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |               |  |                   | 20a. AUTOPSY?  |                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |               |  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/> |                | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |                   |  |                |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |               |  |                   |  |                |  |  |
|  |  |  |  | P.M. 19  |               |  |                   |  |                |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY   |               | 21f. LOCATION  |                   | CITY OR TOWN   |                | COUNTY STATE   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |               | STREET   |                   |  |                |  |  |
| 22a. I certify that (I) (this physician) attended the deceased from 1-27-81, 19 81, to 1-27-81, 19 81, that (I) (we) last saw the deceased alive on 1-27-81, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |               |  |                   |  |                |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |               |  |                   | 22c. DATE SIGNED   |                |  |  |
| Soonchul Hong  |  |  |  |  |               |  |                   | 1-27-81  |                |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |               |  |                   |  |                |  |  |
| SOONCHUL HONG  |  |  |  | Baltimore County General Hospital  |               |  |                   |  |                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |               | 23d. LOCATION  |                   | CITY OR TOWN   |                | COUNTY STATE   |  |
| Burial   |  | 30 JAN 81  |  | Woodlawn Cemetery  |               | Woodlawn, Baltimore, Md.   |                   |  |                |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |               |  |                   | 25b. REGISTRAR'S SIGNATURE                               |                |  |  |
| J. E. Lowell Lemmon Padonia & York Rds.  |  |  |  |  |               |  |                   | 1-28-1981  |                |  |  |



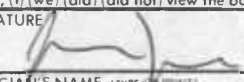



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO. 8100554                                     |                               |  |  |  |                    |  |
|--|--|--|--|---|--|--|--|--|--|--|-------------------------------|--|--|--|--------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  | 1. DECEASED NAME FIRST MIDDLE LAST<br>David Joseph MC COY  |  |  |  |  |                               | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 15, 1981 |  |  | 2b. HOUR<br>2:30AM |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 12, 1954  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>26 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                   |  | IF UNDER 24 HRS<br>HOURS MIN. |  |  |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.  |  |  |  |  |                               |  |  |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Labor  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel |  |                               |  |  |  |                    |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Parkville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>3132 Texas Avenue             |                               |  |  |  |                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Paul MC Coy   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>M. Ilone Calhoun  |  |  |  |  |  |  |                               |  |  |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>----- 217-62-5270  |  | 17. INFORMANT ADDRESS<br>Anna M. McCoy 3132 Texas Avenue Baltimore, Md   |  |  |  |  |                               |  |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis</u><br>5829<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 yr |                               |  |  |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Myocardial infarction</u>   |  |  |  |   |  |  |  |  |  |  |                               |  |  |  |                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                               |  |  |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |  |  |  |                               |  |  |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |                               |  |  |  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |                               |  |  |  |                    |  |
| 22b. SIGNATURE<br>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>Jan 16, 1981   |  |  |                               |  |  |  |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. David Nagel, M.D.  |  |  |  |   |  | 22e. ADDRESS<br>1205 York Road Towson, Maryland  |  |  |  |  |                               |  |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan 17, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Belair Memorial Gard.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Belair, Harford Co., Md.   |  |  |  |  |                               |  |  |  |                    |  |
| 24. FUNERAL DIRECTOR NAME<br>Dippel Funeral Homes, Inc.  |  | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.  |  | 25. DATE REC'D BY REGISTRAR<br>JAN 16 1981  |  | 25. REGISTRAR'S SIGNATURE<br>                                   |  |  |  |  |                               |  |  |  |                    |  |



David Joseph M.D.      1907 York Road      1907 York Road      1907 York Road  
 Baltimore, Md.      Baltimore, Md.      Baltimore, Md.      Baltimore, Md.  
 1907 York Road      1907 York Road      1907 York Road      1907 York Road  
 Baltimore, Md.      Baltimore, Md.      Baltimore, Md.      Baltimore, Md.  
 1907 York Road      1907 York Road      1907 York Road      1907 York Road  
 Baltimore, Md.      Baltimore, Md.      Baltimore, Md.      Baltimore, Md.

**Chronic Otitis Media**

1907 York Road      1907 York Road      1907 York Road      1907 York Road  
 Baltimore, Md.      Baltimore, Md.      Baltimore, Md.      Baltimore, Md.  
 1907 York Road      1907 York Road      1907 York Road      1907 York Road  
 Baltimore, Md.      Baltimore, Md.      Baltimore, Md.      Baltimore, Md.  
 1907 York Road      1907 York Road      1907 York Road      1907 York Road  
 Baltimore, Md.      Baltimore, Md.      Baltimore, Md.      Baltimore, Md.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  | 8100555   |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  | REG. NO.  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>ANNA   |  | MIDDLE<br>S.   |  | LAST<br>McCRACKEN   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-4-1981   |  | 2b. HOUR<br>9:15 AM                                       |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 21 1893  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                  |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Garrison  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GARRISON VALLEY CENTER |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  | 13e. STREET ADDRESS<br>530 S. 45th. Street                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George L. Schmidt   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Mage   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>216-24-3506   |  |   |  | 17 INFORMANT<br>Mr & Mrs Henry C. Doebereiner, Sr.<br>530 S. 45th. Street-Balto, MD. 21224   |  |   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Cerebrovascular Accident<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cerebral Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Many years                  |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 days |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>chronic Brain syndrome   |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 7-6-1977 to 1-4-1981, that (I) (we) lost<br>saw the deceased alive on 1-4-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br>Shankat   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |   |  | 22c. DATE SIGNED<br>1-4-81  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SHANKAT Y. KHAN  |  |   |  | 22e. ADDRESS<br>223 Eastern Blvd, Balto, MD 21221  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/8/1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland              |  | 24 FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>ADDRESS 7922 Wise Avenue Dundalk, MD. 21222                                    |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McBrady   |  |  |  |   |  |   |  |   |  |

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 5 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |   |  |   |  |  |
|--|--|---|---|--|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDNA <del>McDONALD</del> MAE McDONALD</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/26/81</b>                  |  |  | 2b HOUR<br><b>3:05 a.m.</b>   |  |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>white</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 14 90</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Essex</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Riverview Nursing Centre, Inc.</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>     |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Retail</b>   |  |  |
| 13a STATE<br><b>Maryland</b>   |  |   | 13b COUNTY<br><b>Balto.</b>   |  | 13c CITY OR TOWN<br><b>Dundalk</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS<br><b>1952 Guyway 21222</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Wilhite</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Keithly</b> |  |  |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   | 16b SOCIAL SECURITY NO.<br><b>500.10.5646A</b>                        |  | 17 INFORMANT ADDRESS<br><b>Walter McDonald 1952 Guyway Dundalk, Md. 22</b> |   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 days</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive pulmonary disease</b>   |  |   |   |  |  |   |  |   |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-25-80</b> to <b>1-26-81</b> , that (I) (we) last saw the deceased alive on <b>1-23-81</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |   |  |   |  |  |
| 22b SIGNATURE<br><b>W. J. D. S. D.</b>   |  |   |   | DEGREE<br><b>MD</b>  |  |   |  | 22c DATE SIGNED<br><b>1-26-81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. J. D. S. D.</b>   |  |   |   | 22e. ADDRESS<br><b>2900 JONRAN RD.</b>   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/30/1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Walnut Grove Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Boonville Missouri</b>             |  |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc.</b>   |  |   |   | ADDRESS<br><b>Dundalk Md 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1981</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Hebrandy</b>  |  |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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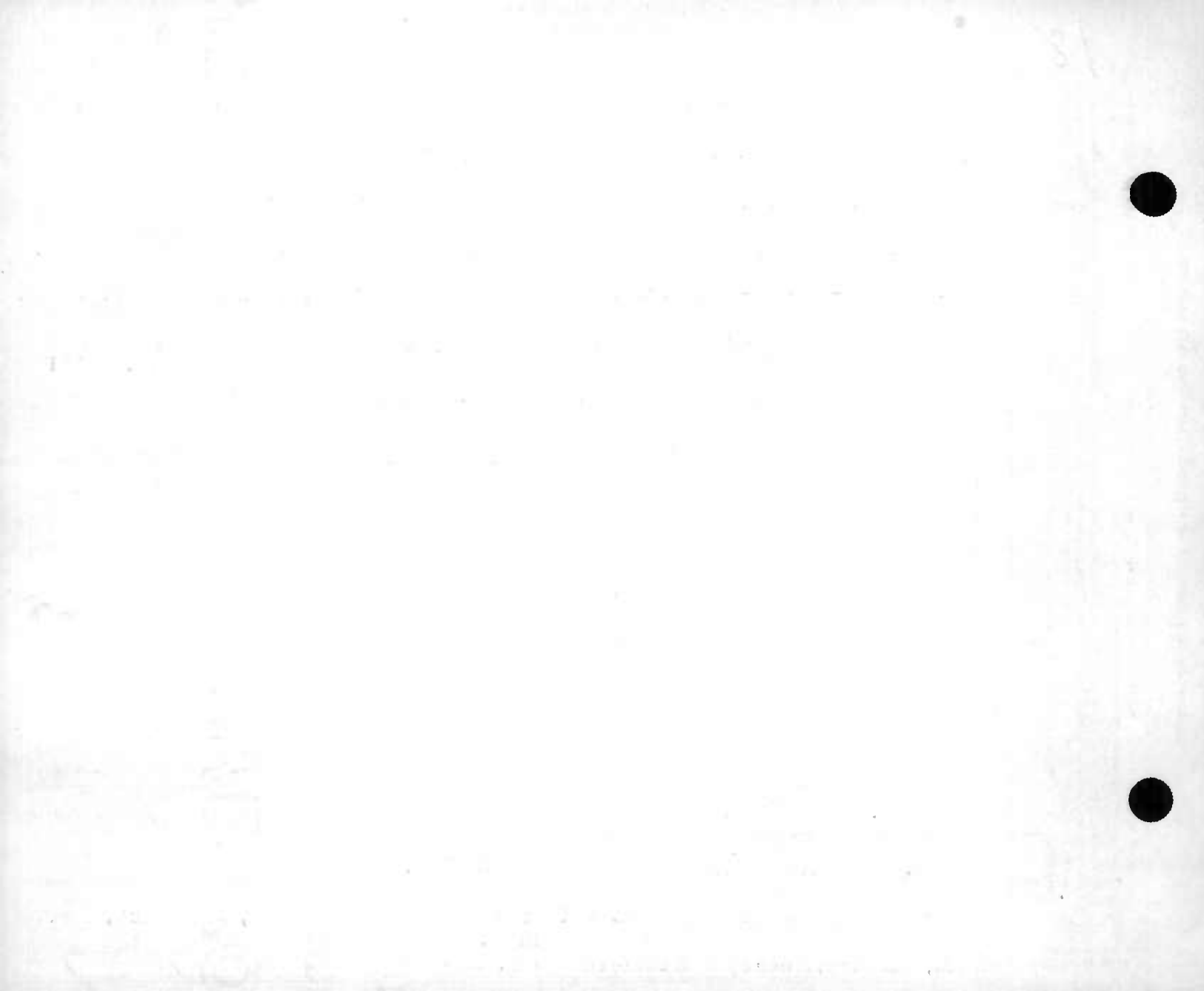
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8100557<br>REG. NO.   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harry Milson McDONALD</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 28, 1981</b>  |  |  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 30, 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Barton, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>College Manor Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Educator</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of Md.</b>   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jmaes John McDonald</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mollie Unknown</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>WW I 212 22 9627</b>   |  | 17. INFORMANT<br><b>James McDonald</b>   |  | ADDRESS<br><b>York Road Monkton Md. 21111</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HAEMO.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b> |  |  |  |   |  |  | r |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Franklin E. Leslie</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>Jan 28/81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Franklin Leslie</b>   |  | 22e. ADDRESS<br><b>3501 St. Paul Street</b>  |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>30 JAN 81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Smith, Fadeley, Keeney &amp; B asford</b>  |  | ADDRESS<br><b>106 E. Ch</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 0 5 5 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |   |  |   |  |
|--|--|---|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANK R. MC GUIRE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>01</b> YEAR <b>81</b>               |   |  | 2b. HOUR<br><b>5:28P</b>  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>3</b> YEAR <b>1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county MD.</b>   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N. CHARLES STREET</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Builder</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Balto</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8419 Tally Ho Rd.</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Frank</b> MIDDLE <b>R</b> LAST <b>McGuire</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b></b> LAST <b>Murphy</b> |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>150 07 2301A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Frank R. McGuire 3rd Same</b>                   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF LUNG</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01/08</b> 19 <b>81</b> , to <b>01/08</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Te-h ching Wang</b>   |  |   |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>01/08/81</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. TEH-CHING WANG</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>1/12/1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemt</b>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Md.</b>                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home</b>   |  |   |   |   |  | 25a. ADDRESS<br><b>6500 York Rd.</b>  |   |  |   |  |

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

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CHARGE - BALTIMORE COUNTY

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GREATER BALTIMORE MEDICAL CENTER

DR. TEN-CHING WANG

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | 8100559   |  |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2b. DATE OF DEATH   |  |  |  | 2c. HOUR  |  |
|   |  | EDGAR M MCKELVEY  |  |  |  | 1-5-81  |  |  |  | 12:10 AM  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7a. MONTH  |  | 7b. DAY   |  |
| MALE  |  | White   |  | Feb. 26, 1872  |  | 88 YRS.   |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |   |  |
| Maryland  |  | U.S.A.  |  |  |  | Baltimore County MD.  |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |  |
| Randallstown  |  | Baltimore Co. Gen. Hosp.  |  |  |  | Sander  |  | Manufacturing  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |   |  |
| Md.   |  | Balto   |  | Reisterstown   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 222 Main St.   |  |   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |   |  |
| John O. McKelvey  |  |   |  | Ida ALuerta Jones  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |  | ADDRESS  |  |   |  |
| No  |  |   |  | 216-01-7037  |  | Anna Cavey  |  | 22 Cocks Mill Rd.<br>Reisterstown Md.                          |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Pneumonia   |  |   |  |  |  |   |  |  |  | Weeks   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |  |  |   |  |
| arteriosclerotic cardiovascular disease   |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
|   |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
|   |  |   |  |  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-30-1980 to 1-5-1981, that (I) (we) last saw the deceased alive on 1-5-1981, and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |   |  |
| Soonchul Hong   |  |   |  |  |  |   |  | 1-5-81   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |   |  |  |  |   |  |
| SOONCHUL L HONG   |  |   |  | Baltimore County General Hospital  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |   |  |
| Burial  |  | Jan. 7, 1981  |  | Jessaps Cem.   |  | Cockeysville, Balto, Md   |  |  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME   |  |   |  | ADDRESS  |  |   |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE        |  |   |  |
| A. S. Schmitt   |  |   |  | Owings Mills, Md   |  |   |  | JAN 8 1981   |  |   |  |



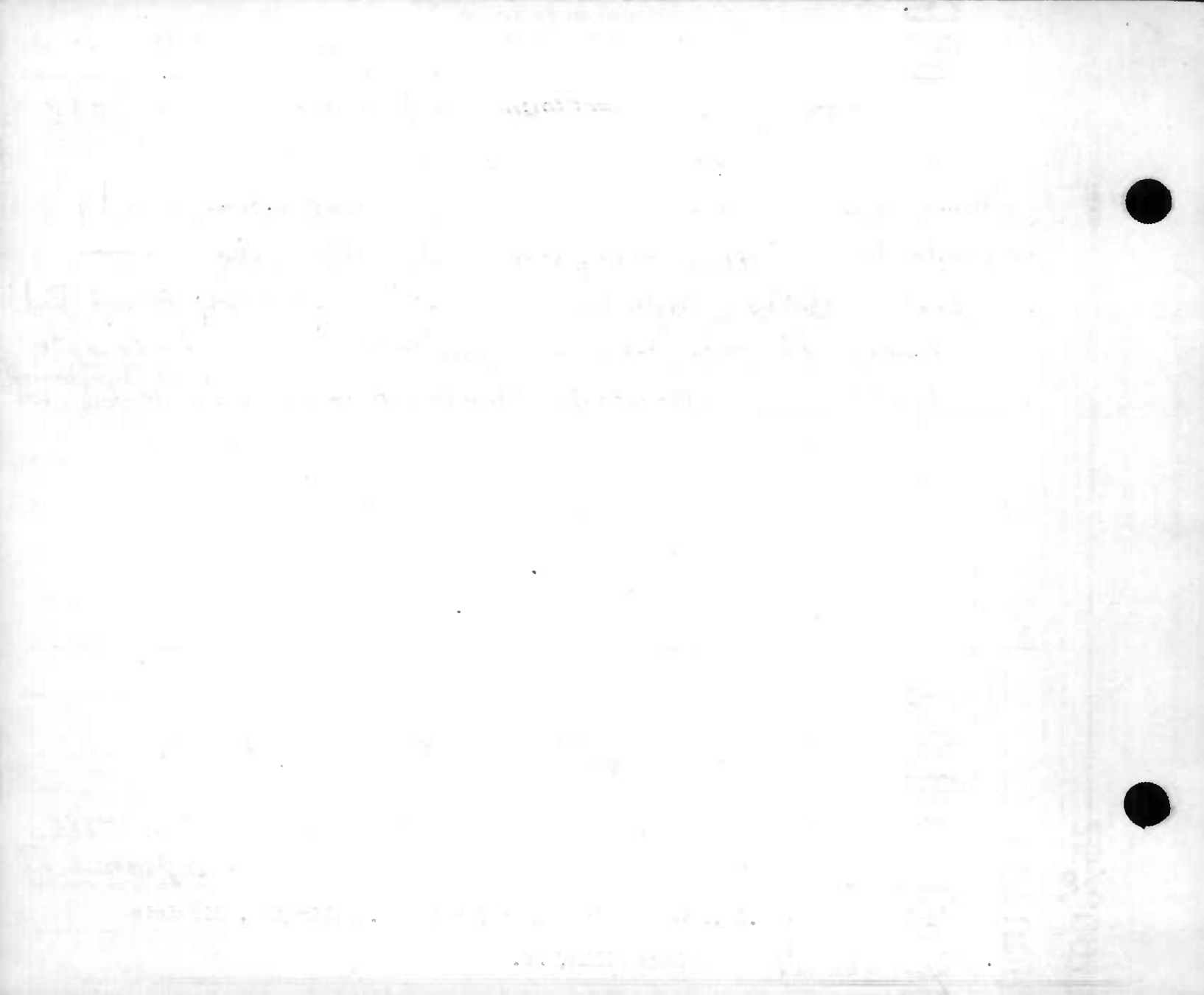
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |                             |   |  |
|--|--|---|--|---|--|---|--|--|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |                             | 2b. HOUR  |  |
| Elizabeth  |  | R.  |  | McLeod  |  | McLeod  |  | 1/14/81  |                             | 11:30 P.M.  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                             | 7b. IF UNDER 24 HRS<br>HOURS MIN.                     |  |
| F  |  | Cau   |  | 3 12 1893   |  | 87 YRS.   |  |  |                             |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                             |   |  |
| Maryland   |  | U.S.A.  |  |   |  | Baltimore County MD.  |  |  |                             |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |  |                             |   |  |
| Reisterstown   |  | 4101 Piney Grove Rd.  |  |   |  |   |  |  |                             |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |  |                             |   |  |
| Housewife  |  |   |  |   |  |   |  |  |                             |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |                             |   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |                             |   |  |
| Md.  |  | Balto.  |  | Reisterstown  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 4101 Piney Grove Rd.   |                             |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |                             |   |  |
| Thomas Alexander Roszell   |  |   |  | Lavinia LeCompte  |  |   |  |  |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT<br>ADDRESS   |                             |   |  |
| No   |  |   |  | 214-52-4192   |  |   |  | Charles H. Gibson 4101 Piney Grove Rd. Reisterstown, Md.   |                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable Myocardial infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hours |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |                             |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |   |  |
| Aug - 1980   |  | Intestinal obstruction  |  |   |  |   |  |  |                             |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                             |   |  |
|  |  | P.M. 19   |  |   |  |   |  |  |                             |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                             |   |  |
|  |  |   |  |   |  |   |  |  |                             |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/14, 1980, to 1/14, 1981, that (I) (we) last saw the deceased alive on December 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |                             |   |  |
| 22b. SIGNATURE   |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |                             |   |  |
| Rolando Vietta   |  |   |  | MD  |  |   |  | 1/14/81  |                             |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |   |  |  |                             |   |  |
| Rolando Vietta MD  |  |   |  | 11 E Chestnut Hill la Reisterstown, Md  |  |   |  |  |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                             |   |  |
| Burial   |  | Jan. 16, 1981   |  | Arlington National Cem.   |  |   |  | Arlington, Virginia  |                             |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  |   |  | ADDRESS   |  |  | 25. DATE RECD. BY REGISTRAR |   |  |
| H. J. Ehrhardt   |  |   |  |   |  | Owings Mills, Md.   |  |  | JAN 15 1981                 |   |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                             |   |  |





TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 81 00561   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LETITIA A. McMAHON</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>01 26 81</b>   |  |   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>09 14 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>717 DEVONSHIRE ROAD</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>  |  |
| 13a. STATE <b>MARYLAND</b>   |  |   |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>KENSINGTON</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK BROOKE</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO <b>218-48-4784</b>  |  | 17. INFORMANT ADDRESS <b>RICHARD R. McMAHON 1102 VERNON AVENUE, 21229</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4292 ASCVD, advanced with</b>  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac arrhythmia</b>   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac arrhythmia</b>   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>81</b> , to <b>1/26</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>1/13</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did (did not) view the body after death.) |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Herbert J. Levickas M.D.</b> DECEASED ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED <b>1/26/81</b>  |  |   |  |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HERBERT J. LEVICKAS, M.D.</b>  |  |   |  | 22e. ADDRESS <b>5404 EAST DRIVE: BALTIMORE, MD. 21227</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>01-29-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>  |  | ADDRESS <b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D BY REGISTRAR <b>JAN 28 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8100562

REG. NO.

|   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR  |  |  | 2b. HOUR   |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Paul A. McNickle</i>  |  |  | 1   |  |  | 6   |  |  | 81   |  |  |
| 3. SEX<br><i>Male</i>   |  |  | 4. RACE<br><i>White</i>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 22 1923</i>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>57</i> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington, DC</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore County General Hospital</i> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Court Reporter</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Baltimore Co.</i>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>   |  |  | 13c. CITY OR TOWN<br><i>Pikesville</i>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Thomas J. McNickle</i>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Christine Rankin</i>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>Yes WWII</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>578-09-0819</i>   |  |  |
| 17. INFORMANT<br><i>Mrs. Nancy McNickle</i>   |  |  | ADDRESS<br><i>605 Milford Mill Rd., Baltimore, MD 21208</i>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Atherosclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Hypertension</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immediate</i> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-16</i> , 19 <i>67</i> , to <i>1-6</i> , 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>8-22</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Frank G. Kuehn</i>   |  |  | DEGREE<br><i>MD</i>   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  | 22c. DATE SIGNED<br><i>1/7/81</i>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>FRANK G. KUEHN</i>  |  |  | 22e. ADDRESS<br><i>7600 OSLER DRIVE TOWSON 4</i>  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>1/9/81</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge Cemetery</i>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Pikesville, Baltimore, Md.</i>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors, P.A.</i>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 9 1981</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |
| 26. ADDRESS<br><i>8728 Liberty Rd., Randallstown, MD 21133</i>  |  |  |   |  |  |   |  |  |  |  |  |

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